Sussex Health and Care Partnership

Strategic Delivery Plan

Response to the Long Term Plan

28th October 2019

DRAFT Version 17

Patient-centred
Partnership Transformation
Sussex
Integration Sustainability 15 Social care Health

Table of Contents

1. Executive Summary

The Sussex Health and Care Partnership is a new footprint which serves a **large and varied population of 1.7 million people** and is responsible for **£4bn of health and care spending**, delivered by **over thirty thousand staff**.

It is a complex system with multiple providers, commissioners and partners. We are currently on the journey to transition from the **previous Sussex and East Surrey Sustainability and Transformation Partnership** towards our **new Sussex Health and Care Partnership**.

1.1. Our ambition

We aspire to have a responsive and adaptive system **co-designed in partnership with our Sussex population** around the outcomes that matter to them, providing sustainable care which suits the needs of our population. We will deliver this through an **integrated population health management approach** which segments our population based upon need, to provide the best possible care whilst ensuring that there is not unwarranted variation in outcomes.

We will take a holistic approach to supporting our population's health and wellbeing of mind and body in an integrated way. This will require new ways of working with Sussex health and social care organisations to determine the models of care that best suit our population, considering the wider determinants of people's health and care needs to develop an increasing role for the wider community and voluntary sector in addressing those needs. The role of the individual is critical in this and we will use the resources of our large and highly skilled staff to support our population to have the knowledge, skills and confidence to protect and manage their own health.

Our population health management approach will be planned and delivered collaboratively through organisation-agnostic Integrated Care Teams working within the community. The specific composition of teams will depend upon the need of the local area and the outcomes that matter to that population. These will involve existing clinicians and practitioners across organisations, with some additional roles including social prescribers, working together in a different way to deliver high quality, joined-up care. By making services responsive and flexible, we will address the priority areas for outcomes improvement which account for 75% of deaths and disability across our footprint. These include cancer, mental health problems and cardiovascular & respiratory disease, alongside our prevention priorities of smoking, obesity and alcohol.

1.2. Our strengths

Sussex has considerable strengths in how we deliver health and social care, which provide a clear platform upon which to build our system aspirations. We have demonstrable strengths across our footprint:

- The **East Sussex Better Together** programme has led the way for integrated service planning and transformation with both social care and health
- **Western Sussex Hospitals Trust** continues to be rated 'Outstanding' by the CQC
- **Sussex Community NHS Foundation Trust**, **Sussex Partnership NHS Foundation Trust** and **Brighton and Sussex University Hospitals** are rated 'Outstanding' in the 'Caring' domain

- **Queen Victoria Hospital** continues to be rated by patients as one of the country's top hospitals for quality of care
- **Sussex Partnership Foundation Trust** has led a strong Sussex-wide partnership programme approach for Mental Health that has resulted in winning funding for innovative new services
- 95% of our **GP practices** are rated good or outstanding
- Our **Ambulance Trust** continues to improve 999 services, recently receiving a CQC rating of 'Good' overall, including 'Outstanding' for Caring
- Across emergency and urgent care, our collaborative system-wide work to reduce hospital handover times and improve services for mental health patients have both been rated 'Outstanding'.

We have collectively delivered **amongst the most significant improvements in financial position nationally since 2017**, with a 2.4 percentage point improvement in overall surplus / deficit against a national background of declining performance. A significant proportion of contracts are already aligned incentive contracts for 2019/20 and we are exploring risk sharing models to stimulate delivery of our new models of care. The Partnership is committed to identifying innovative and benefit-sharing options to engage both providers and commissioners.

Some of our CCGs and providers have also successfully moved out of financial and quality special measures recently, demonstrating that across all of our system partners, providers and commissioners, Sussex has great strength and is continually delivering improvements.

Our current strategic planning has been rooted in a **strong commitment to developing our services in partnership with our staff, patients and the public**. Through our public engagement, we have heard from around 1,500 people in Sussex through a combination of open engagement events, focus groups and online surveys. This has included members of the public, patients, carers, people experiencing mental health problems, physical and sensory disabilities, people from diverse ethnic backgrounds, and former members of the UK Armed Forces, together with colleagues from voluntary and community sector organisations, partners and clinicians. We have undertaken extensive engagement across all partner organisations, with input from hundreds of staff across health and care.

1.3. Addressing our challenges

Alongside our considerable strengths and recent progress, we acknowledge that there are several challenges facing the delivery of sustainable services in Sussex, which we will address through our new ways of working.

To realise our ambition of providing sustainable care suited to the individual needs of our population, we **must tackle the financial challenge that our system faces**. The **current projected deficit** for NHS providers and commissioners in our Partnership is **£(74.4)m (2.7% of total commissioner spend) for 2019/20**.

Our "do nothing" financial challenge as a Partnership is a **pre-sustainability funding deficit of £(284.5)m (8.9% of total commissioner spend) in 2023/24**, driven by rising demand and cost inflation. Our financial planning will need to leave us headroom to meet constitutional standards, including revised access standards to be implemented from Spring 2020. In addition, we will face a

Page 5 of 185

potential continuing workforce gap of 11.2% overall in 2023/24, representing 3,920 WTEs.

Realising our ambition will require us to **strengthen existing relationships between primary, acute, community and mental health services**, and to **expand our system governance to further reinforce relationships with local authorities**, including district and borough councils, and the voluntary and community sector.

At the neighbourhood level, **one or more of our 38 Primary Care Networks (PCNs) will bring together GPs to work with local community services, mental health, social care, pharmacy and voluntary sector teams**, to collaborate to provide integrated local health and care for patients and the population. This will enable patients to experience well-planned services, appropriate to their needs, and seamless pathways. PCNs will also be involved in the **planning, design and delivery of local services** and service improvement to improve health and outcomes in neighbourhoods.

To facilitate greater partnership working, we plan to have **three CCGs and three 'places' contiguous with local authority boundaries, working with neighbourhoods**. Each place will function as a **collaborative planning unit and transition to an Integrated Care Partnership (ICP)**, an alliance of neighbourhoods and sovereign providers that will bring together health and social care providers and commissioners. ICPs will support the delivery of acute and community care, hosting Integrated Care Teams with easy access to secondary care expertise and using a population health management approach to segment and actively plan services.

As a **future Integrated Care System (ICS)**, our Sussex scale system will build from local neighbourhoods to deliver those **functions that are best managed across the whole of Sussex**. This is likely to change over time as the ICPs develop and are able to address more of the issues at scale.

Our system reform will have to reflect the varying maturity of development within these proposed ICPs and amongst our PCNs, including the provision of additional support for organisational change and PCN development. In addition, we will work with our neighbouring systems in Surrey and Kent to ensure our planning and care delivery takes into account actual patient flows.

1.4. Our plans to deliver system priorities

Our strategy encompasses clearly articulated plans which are based upon our strengths as a system. The system strengths and our skilled staff will be key in delivering our system priorities and addressing the current and future challenges.

We will **work in a different way with the public** to collaborate to set outcomes and ensure that our population is at the front of the design of our new services. The Health and Care Strategic Model establishes this new method of service delivery which differentiates care delivery at neighbourhood, place and Sussex-wide level to ensure that all individuals receive the best care in the best environment.

Our staff working across primary, acute, community, mental health and social care will come together to support people to manage their social, physical and mental health and wellbeing. This allows the **places to focus on population health management and joined-up care through**

Integrated Care Partnerships and achieves the best outcomes across Sussex by working in partnership to deliver high quality specialist and complex services. Our model has been designed by clinicians and agreed by the system, based upon the themes raised by our local population as part of public engagement, and focuses upon the key building blocks of prevention, addressing the wider determinants of health and empowering individuals to manage their own health and care needs.

We will **deliver bespoke programmes of work** to address key issues and areas of unwarranted variation, including stroke, ageing, and learning disabilities & autism, with a **robust delivery and governance framework to ensure accountability for delivering outcomes**.

To **address our financial deficit**, our delivery plans will meet prescribed trajectories and we have developed a financial framework to help guide financial planning and contracting over the coming months. We will change the way that we assure financial performance and align this to a population health management approach to underpin our new health and care strategic model. Local authorities have also been included within the financial framework as a first step to further strengthening our relationships and developing integrated community services. We will work as a system to ensure we continue to deliver the best outcomes for public finances, using **evidence-based decision making to prioritise service transformation**.

Alongside detailed plans to **address our workforce gap and improve our future workforce supply**, we recognise the critical role our staff play in the delivery of our vision. We can only deliver these plans by maximising the workforce contribution to facilitate a shift in culture and ensure that health and care are everyone's responsibility. In turn, we will need to upskill our staff to achieve this, ensure our workforce are happy and healthy, and establish the role of our health and care structures as anchor organisations to influence the wider determinants of health. We know we need to go further to support our people and are prioritising plans to improve mental and physical health and wellbeing, promote flexible working, and provide continuing professional development opportunities including development of new roles and leadership capabilities.

As we **undertake this wide scale system reform and service transformation**, it is more important than ever to ensure we provide services of the highest quality, delivered with respect and compassion, and provide a positive care experience for our population. Our developing plans will all be assessed for their impact on quality of care and health inequalities, alongside ongoing performance monitoring of providers against standards and outcomes across patient experience, patient safety and clinical effectiveness. To further strengthen our quality assurance, we will ask our local population to identify the outcomes that matter to them and use these to monitor performance and develop targeted improvement interventions.

1.5. Delivery through collaboration

Collaboration across the ICS will provide the mechanisms needed to deliver our system priorities through service and partnership development. We have already made significant strides on our journey towards greater integration and development as an aspirant ICS, including:

- Convening a **transparent Partnership Executive Group** which includes representatives from all NHS organisations and county councils

Page 7 of 185

- Aligning our new governance structures, including shifting towards a **single SRO and independent chair**
- Establishing **Primary Care Networks (PCNs) across Sussex**, with nominated Clinical Directors for each
- Assembling a **Clinical and Professional Cabinet** to provide clinical system leadership, with representatives from all NHS providers and commissioners, public health and primary care, who have collaborated to develop our health and care strategic model
- Ensuring that our **Finance Group** now operates as a **strong and effective vehicle for cross-system collaboration**, with an agreed finance, activity and workforce model
- Forming the **Acute Care Collaborative Network**, which will facilitate system-wide collaboration and transformation across Sussex.

Our ambition is to become a **'maturing' ICS by April 2020** supported by our status on the ICS Accelerator Programme. Despite our considerable strengths and recent progress, we recognise that a significant amount of work will be required to reach our goals, in particular around further defining our system architecture (including the development of ICPs and PCNs), reforming our commissioning model, establishing a Population Health Management approach and building a shared quality, performance and financial assurance system. We look forward to working with the regulator to enable effective deployment of our strategy, and strengthen how we work collaboratively as a system to deliver the strategic plan.

1.6. Our Strategic Delivery Plan

Our Strategic Delivery Plan lays out the specific proposals to deliver the ambition highlighted above, including:

- Further detail relating to our **health and care strategic model**, including descriptions of how the model will be delivered and be both clinically and locally-led
- Our **system-wide agreed financial framework**, which underpins our delivery
- Our **transformation priorities**, focusing specifically on those priorities set out in the **Long Term Plan** and identified in our **Population Health Check**
- **Comprehensive governance and clear mechanisms** for tracking delivery and monitoring progress against our priorities and the targets.

We are acutely aware that our Strategy Delivery Plan includes commitments to address our financial deficit, address our workforce gap, reform how our Sussex health and care organisations work together, transform patient pathways, and deliver the significant number of initiatives included within the Long Term Plan. Each of these are challenging to deliver in themselves but **together require profound and extensive system transformation**.

Successful delivery of all these commitments will require us **prioritise the reforms with the greatest impact across the system and to form new ways of working to provide the bandwidth to deliver**. As of October 2019, we are beginning forward planning to enable us to move directly into operational delivery planning. While our Strategic Delivery plan sets out what we want to achieve and the principles of how we will work together differently, our **operational planning will set out how we will achieve this and what needs to change to enable this**.

2. Context: Our footprint and population need

2.1. Our Sussex footprint

Our footprint is home to over 1.7 million people and our Partnership provides health and social care for these people at a cost of £4bn per year. Having recently undergone a reorganisation to change from the Sussex and East Surrey STP to the Sussex Health and Care Partnership, we now comprise seven CCGs, seven statutory providers (excluding GP providers), and three local authorities:

- Brighton and Hove City Council
- Brighton & Hove CCG
- Brighton & Sussex University Hospitals NHS Trust
- Coastal West Sussex CCG
- Crawley CCG
- East Sussex County Council
- East Sussex Healthcare NHS Trust
- Eastbourne, Hailsham and Seaford CCG
- Hastings and Rother CCG
- High Weald Lewes Havens CCG
- Horsham and Mid Sussex CCG
- Queen Victoria Hospital NHS Foundation Trust
- South East Coast Ambulance Service NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- West Sussex County Council
- Western Sussex Hospitals NHS Foundation Trust

We maintain our close relationships with providers First Community Health and Care and IC24, and continue to work closely with East Surrey CCG, Surrey and Borders Partnership NHS Foundation Trust, Surrey and Sussex Healthcare NHS Trust and Surrey County Council.

West Sussex 852,000 people

East Sussex 555,000 people

Brighton & Hove 290,000 people

Figure 1: Our Sussex footprint and population

Page 9 of 185

2.2. Our population need

We carried out a Population Health Check in 2018/19, which was developed by local doctors, specialists and clinicians to understand and describe the current state of health of the Sussex population. It also identified areas of concern and where the care provided was less than optimal. These concerns were also reflected by the public during our recent engagement process.

Our health profile, and hence priorities, are largely in line with the rest of the country. However, there are significant variations across our footprint in terms of socioeconomic status, health outcomes, environment and economic prosperity, which are often masked by averages.

The resident population across the overall area is projected to increase between 2016 and 2030, from a projected range of between 9.2% increase in the Central Sussex and East Surrey Commissioning Alliance south area (covering Brighton & Hove and High Weald Lewes Havens CCGs) to a 12.0% increase across Coastal West Sussex. The Over-85 group will see the largest increases, with population growth of between 32.5% and 42.1% predicted over the same time period.

Although the majority of our CCGs have a healthy life expectancy,[1] higher than the national average, this is not universal across our footprint. The variation in male healthy life expectancy is 6.6 years between the lowest and highest ranked CCGs (62.5 years in Hastings & Rother and 69.1 in Horsham & Mid Sussex). Hastings & Rother also has the lowest female disability-free life expectancy, at 64.1 years, compared with Horsham & Mid Sussex at 69.4 years.

Similarly, while Sussex is fairly affluent overall, there are pockets of significant social deprivation, notably along the coastal strip in Hastings, Brighton & Hove and Littlehampton, which rank within the most deprived areas in England.

We have a significant mental health need; severe mental illness is 5% higher than the national average and this represents around 25,000 people. We also have rates of dementia that are 25% higher than the national average, with significant concentrations of elderly populations within West Sussex in particular. The health and life outcomes for people experiencing mental health issues will continue to fall short of those of the general population unless we act to deliver the opportunities aligned with the Mental Health Five Year Forward View and the commitments of the Long Term Plan.

If we segment our population by age, we can see that there are a number of areas where focused effort will be required to ensure that everyone starts well, lives well and ages well across Sussex:

---

[1] Healthy life expectancy is an estimate of the number of years lived in 'very good' or 'good' general health, based on how individuals perceive their general health. Disability-free life expectancy is an estimate of the number of years lived without a long-lasting physical or mental health condition that limits daily activities.

Children and young people

2x National average

We have more children and young people smoking at the age of 15 than the national average - Brighton & Hove is double the national average with 15%.

Year 6 15% pupils are obese

15% of our year six pupils are obese and there are higher rates in deprived areas.

We have higher rates of hospital admissions for self-harm of children and young people aged 10-24 compared with rest of England, particularly in Brighton & Hove and Hastings.

Figure 2: Our population – children and young people

Adults[2]

250,000 Smokers on GP registers

We have 250,000 smokers on GP registers, with high rates in Brighton & Hove and Hastings.

155,000 =10% adults with depression

We have over 155,000 adults with depression on GP registers, which is 10% of patients.

27% Eastbourne   78% Brighton

Physical activity rates vary across the area, with 78% in Brighton & Hove and 27% in Eastbourne undertaking regular physical exercise.

Figure 3: Our population – adults

---

[2] Physical activity rates are the percentage of adults estimated to undertake less than 30 minutes of physical activity per week

Working in partnership across Sussex

Older people

18,000+

We have over 18,000 people on the dementia register and many more are not diagnosed.

15,000 carers aged 65+

of 183,000

We have over 183,000 carers, with 15,000 carers aged 65 and over.

110k

We have over 111,000 old people who live alone.
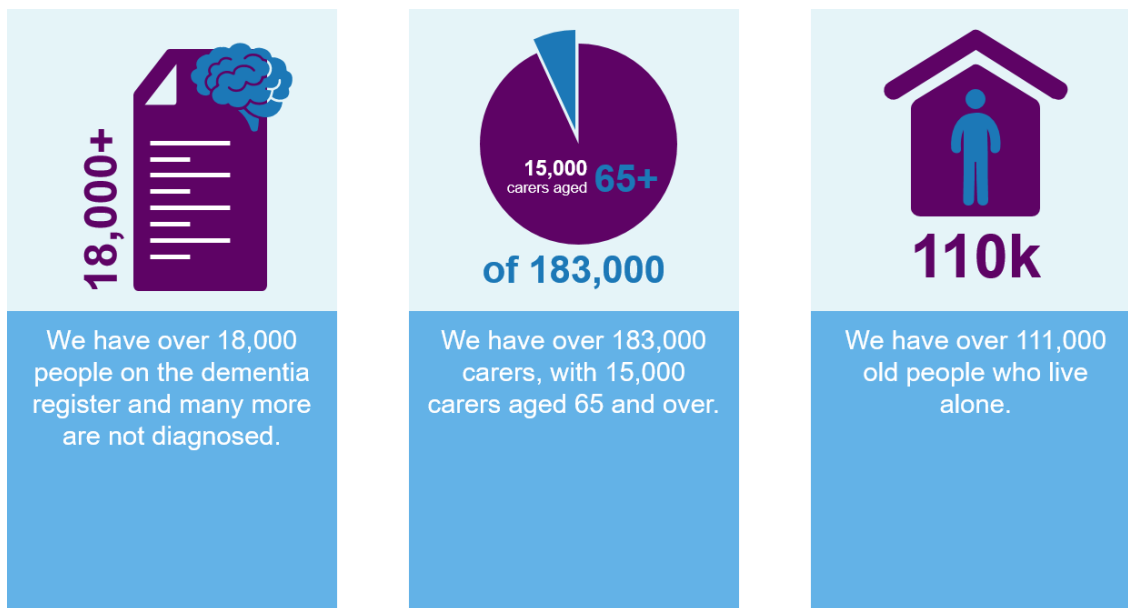
Figure 4: Our population – older people

Dying well

50.7%

die in their usual place of residence

50.7% of our population die in their usual residence but this is only 37.2% in Crawley.

Figure 5: Our population – dying well

Working in partnership across Sussex

2.3. Our progress to date

Over the last 12 months Sussex has made considerable progress across financial, quality and performance metrics:

- We have reduced our deficit and improved our financial position, against a background of national decline in financial performance

- Our improvements have been recognised by the regulator, with Brighton & Sussex University Hospitals NHS Trust (BSUH) and East Sussex Healthcare NHS Trust (ESHT) lifted out of financial special measures and legal directions against three CCGs lifted

- A&E performance has also improved, in a context of national decline in 4-hour performance standards

- All providers have improved or maintained their CQC rating, with 86% of providers holding a 'Good' or 'Outstanding' CQC rating.

Sussex Providers	2017/18 Year End	Latest rating (as at Sept. 2019)
Brighton and Sussex University Hospitals NHS Trust	Inadequate	Good
East Sussex Healthcare NHS Trust	Requires improvement	Requires improvement
Queen Victoria Hospital NHS Foundation Trust	Good	Good
South East Coast Ambulance Service NHS Foundation Trust	Inadequate	Good
Sussex Community NHS Foundation Trust	Good	Good
Sussex Partnership NHS Foundation Trust	Good	Good
Western Sussex Hospitals NHS Foundation Trust	Outstanding	Outstanding

Figure 6: Our Sussex providers' CQC ratings

Against the backdrop of this success in finance, quality and performance, we have worked together across the system to develop more joined-up and clinically-led health and care services that have brought real benefits for patients. We have system-wide governance to align us on clinically-led health and care services:

- We have brought together our most senior medical and nursing leadership in the Clinical and Professional Cabinet to set our clinical priorities for the Partnership

- Our three places each have a Health and Wellbeing Board with representation from both NHS organisations and the Local Authorities, and have each produced a Joint Health and Wellbeing Strategy which sets out a clear vision, goals and ways of working to improve the health and wellbeing of all residents in Sussex

- We have over 30 clinical networks in Sussex, the most developed of which involve formal governance across system partners and commit to sharing activities and resources

Page 13 of 185

- Organisationally, our CCGs have begun to work closely together under one management team which has led to benefits in how services are commissioned, how the limited resources are used, and how our CCGs work

- For the first time, a system-wide business plan has been developed and agreed for 2019-20, which will help ensure services are planned, delivered and paid for in a more consistent and effective way.

Our joint working is demonstrable on the ground, with two strong examples being practitioners from East Sussex Healthcare NHS Trust and East Sussex Adult Social Care now providing joint services for falls, frailty, crisis response and proactive care, and the Local Maternity System bringing together partners that support the provision of maternity services with the aim of improving safety, choice and more personalised care.

This greater emphasis on collaborative working will continue in the year ahead as we lay the foundations to ensure that our Partnership can develop into a maturing Integrated Care System (ICS) by 2020. There will be particular focus on ensuring all our partners can equally contribute to strategic work across Sussex and take more collective responsibility for managing resources, delivering NHS standards and improving the health of our populations.

3. Our health and care strategic model to drive transformation

3.1. Our strategic intent

Our Sussex Strategy Delivery plan responds to the needs of our local population, as identified in the Population Health Check, and envisions the future of health and care in Sussex.

Our Population Health Check described the current state of health of the Sussex population. It also identified areas of concern and areas where care provided was less than optimal. These concerns had also been identified by the public during our recent engagement process. Our Sussex Strategy Delivery plan aims to address these concerns and describe the future of health and care in Sussex.

Demand for our health and care services is rising due to a number of factors, including our growing and ageing population. The success of promoting longer life creates pressures as more people live for longer with one or more long term conditions, which necessitates a greater focus on social care in the community.

Historically, health and care services across primary care, community, mental health, social care and acute services have developed in relative isolation, and this has created barriers for our population. Now we have the **opportunity to integrate these services** and provide a coordinated end-to-end pathway for local people.

In addition, we have an increasingly engaged population; people want to be actively involved in their care and central to any decision making related to their wellbeing.

Whilst recognising the progress that we have made, this strategy responds to the needs of the Sussex population and describes how we will advance our model of care to deliver the highest-quality health and care services across Sussex.

Specifically, the strategy aims to:

- Strengthen the pivotal role of **prevention** from birth and the need to address the wider determinants of health. Our approach reflects the responsibilities of the whole system in addressing health and wellbeing – NHS, councils, police, education, voluntary sector, communities and individuals
- Recognise the importance of health literacy, **supporting people to have the knowledge, skills and confidence to self-manage**, protect their own health, and engage in treatment/care plans both independently and in partnership with professionals
- Address the need for responsive and flexible services, supported by effective use of **technology**
- Address the growing number of people with **long term conditions** who want to have a key role in managing their own care
- Improve **access to urgent care** for those who need a quick and effective response
- **Harness the potential of specialist services**, as well as breakthroughs in medical science and use of data, to maximise the benefits to our whole population.

3.1.1. Integrated commissioning

Wider determinants of health – including education, employment, income, discrimination, and safe and resilient communities – have a significant impact on the health of the Sussex population.

The local CCGs plan to strengthen local planning through organisational mergers, to avoid the fragmentation of the healthcare system. Integrated commissioning and care will be key to positive health and care outcomes and to effective delivery of this health and care strategic model.

Health and Local Authority commissioners will work together on delivery of health and care services, as well as on a programme to **address current inequalities,** in order to improve the health and wellbeing of our population from birth to old age.

3.1.2. Integrated care

Providers already work closely together across Sussex for the benefit of local people, and we will continue to develop these relationships. The bedrock of the Sussex integrated care model is close and effective working between primary and urgent care, community and mental health services, social care and the voluntary sector, to ensure that all individuals receive the best care in the best environment, with high quality care delivered at every level.

At the **neighbourhood level**, one or more **PCNs will bring together GPs to work with local community services, mental health, social care, pharmacy and voluntary sector teams**, to provide integrated health and care for patients and the population, alongside promoting quality and safety. This will enable patients to experience well-planned services, appropriate to their needs, and seamless pathways.

Integrated Care Partnerships (ICPs) will use the wealth of data that we have to understand the needs of, and actively plan services for the benefit of, our population. They will work collaboratively to co-design and deliver care pathway solutions to address unwarranted clinical variation and improve outcomes. Fundamental to this will be using integrated health and care records.

We will ask our population to identify the **outcomes that matter to them**, and use this information in assessing the performance of ICPs and to drive continuous improvement. We expect these outcome measures to inform the development of Integrated Care Teams. These teams will work with a **defined population segment** and account for outcomes that people have said matter to them.

To enable our teams to work well together, we will re-define our clinical, professional, operational and financial accountabilities to better reflect the scope of the Integrated Care Teams. Collaboration between urgent care and both neighbourhoods and ICPs will be fundamental to delivering the most effective and consistent outcomes at the appropriate level. Provision of integrated health and care records will also be central to successful delivery.

To deliver the Sussex Model outlined below, we need to work collaboratively with all health and care providers, who in turn must work closely with our commissioners. For our model to be successful, all organisations must be financially sustainable. Our financial framework must gradually increase the proportion of total resource spent on primary and community care without

undermining performance in the acute setting.

We are tremendously excited by this intent for health and care in Sussex, and look forward to working together with all of our colleagues to turn this intent into a reality.

3.2. Our health and care strategic model

Our future vision represents a new way of working for our system. We have developed our new clinically-led Health and Care Strategic Model, which sets out our new way of organising and delivering services. This section contains further detail on how each of these elements will work and come together to deliver our overall vision.

3.2.1. Three levels of the Sussex Health and Care Model

The Sussex Model is based upon the principle of health and care being delivered at three levels: neighbourhood, local area and Sussex. It is underpinned by the three fundamental building blocks: prevention, services that address the wider determinants of health, and enabling people to manage their own health and care.
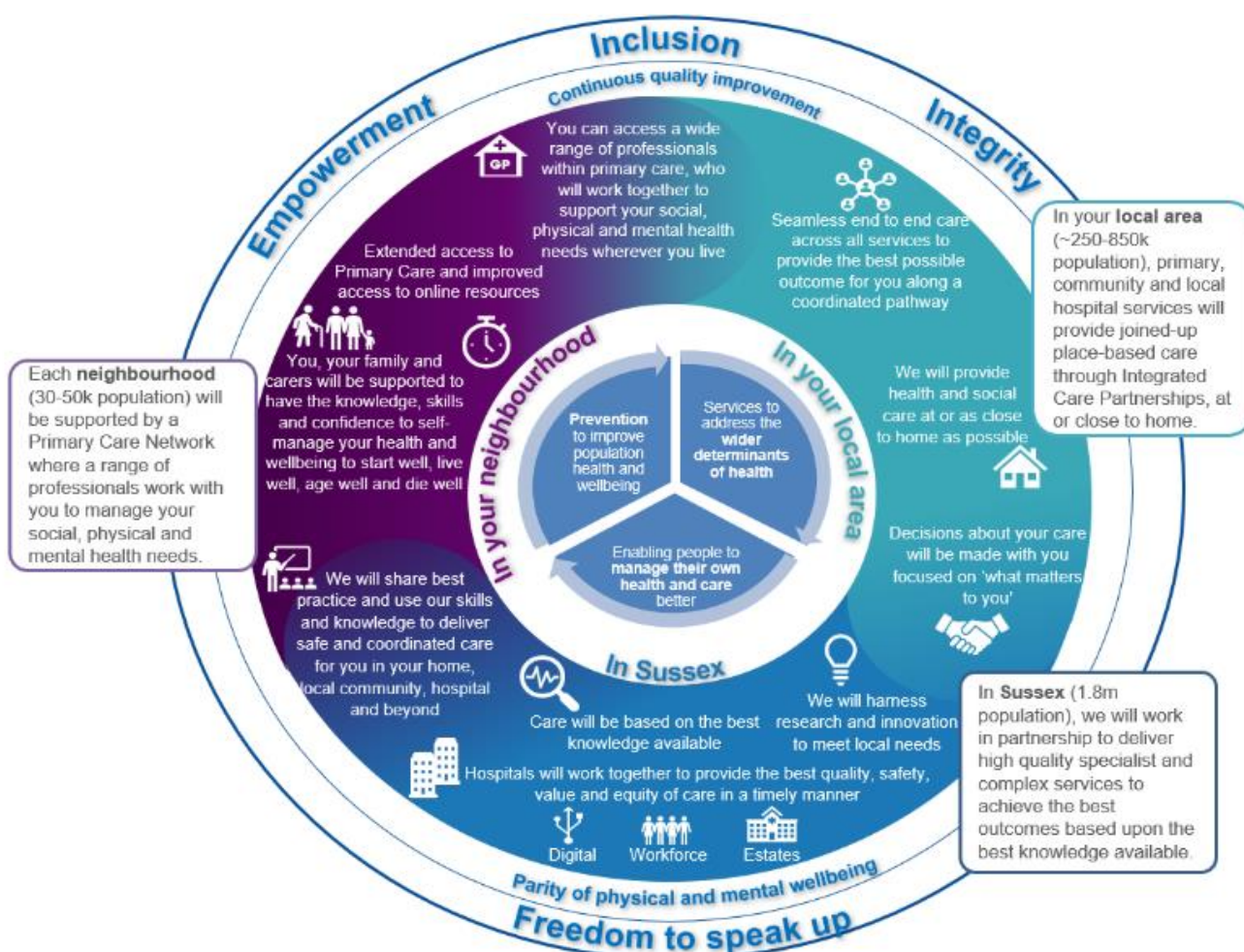

Figure 7: Our Sussex Health and Care Strategic Model

3.2.2. Three building blocks of the Sussex Health and Care Model

- The impact of a person's social circumstances and environmental surroundings, including employment and housing, and factors such as loneliness and isolation, influence the uptake of unhealthy behaviours which go on to account for a high proportion of disease and disability
- Many of the strongest predictors of health and wellbeing are **wider determinants of health which drive inequalities**. These include economic, social and environmental factors, which fall outside the scope of NHS and social care services
- The poorest and the most deprived people are more likely be in poor health, have lower life expectancy and have a long term condition or disability. Some groups such as BAME, LGBT+, people with special educational needs and disabilities, people with long term mental health problems and carers, etc. may require more intensive support and additional help to access services
- The four unhealthy behaviours of smoking, alcohol misuse, poor diet and physical inactivity, along with social isolation and poor emotional and mental wellbeing, are responsible for at least a third of ill health and are amenable to cost-effective preventative interventions
- Individual service prevention interventions improve health and wellbeing, and reduce inequalities. They also build stronger and more resilient communities and places which **support people to maintain independence, make heathier choices, and manage their own health and wellbeing** across the course of their lives. These are important components of a whole system approach to prevention across the NHS, Local Authorities, the voluntary sector, community groups and wider stakeholders.
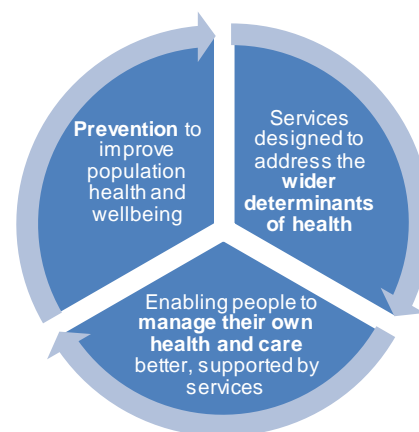
Figure 8: The three building blocks of our Sussex Health and Care Strategic Model

How will services be provided?

These building blocks will be at the centre of our approach to designing health and care services, including:

- Engaging the population in co-design to identify need, shape services and to be involved in implementation
- Using data and technology to empower people to manage their own health and care, including online access to their records, online information and consultation, and direct appointment booking into different care settings
- Providing access to advice and support for the whole population to keep themselves well
- Increasing the use of social prescribing to enable personalised solutions for individuals, and improved integration of clinical and non-clinical services
- Giving the population direct access to a broader range of health and social care providers, for example clinical pharmacists and first contact physiotherapists.

Page 18 of 185

3.2.3. **Your neighbourhood**

Each neighbourhood will be supported by a Primary Care Network (PCN), where primary and community teams work with individuals to look after their health and wellbeing.

How will it work?

- Community and other local services will be designed around neighbourhoods to ensure optimum integration of care – bringing social, physical and mental health together and delivery closer to home. PCNs will work with social care and the voluntary sector, as well as neighbourhood health services, to coordinate and integrate delivery.
- Each neighbourhood will be supported by the equivalent of 10-18 additional staff by 2023/24 through the new GP contract.[3] Expanded neighbourhood teams will comprise a broader range of staff including clinical pharmacists, physician associates, first contact physiotherapists, first contact community paramedics, community geriatricians, dementia workers, mental health practitioners and social prescribing link workers.
- We will support the physical and mental health of the local population by using data and involving local people and their feedback to appropriately target our services, build an in-depth understanding of health needs and inequalities, and develop multi-disciplinary, cross-sector teams to take responsibility for these needs, e.g. when delivering social care.
- PCN teams will be supported by easy access to and partnership with local hospices and specific secondary care expertise.

Care is centred around the PCN: a group of GP practices work with local community services, mental health, social care, pharmacy and voluntary sector teams to support individuals to look after their health & wellbeing

Mental health teams

Social care

Voluntary sector
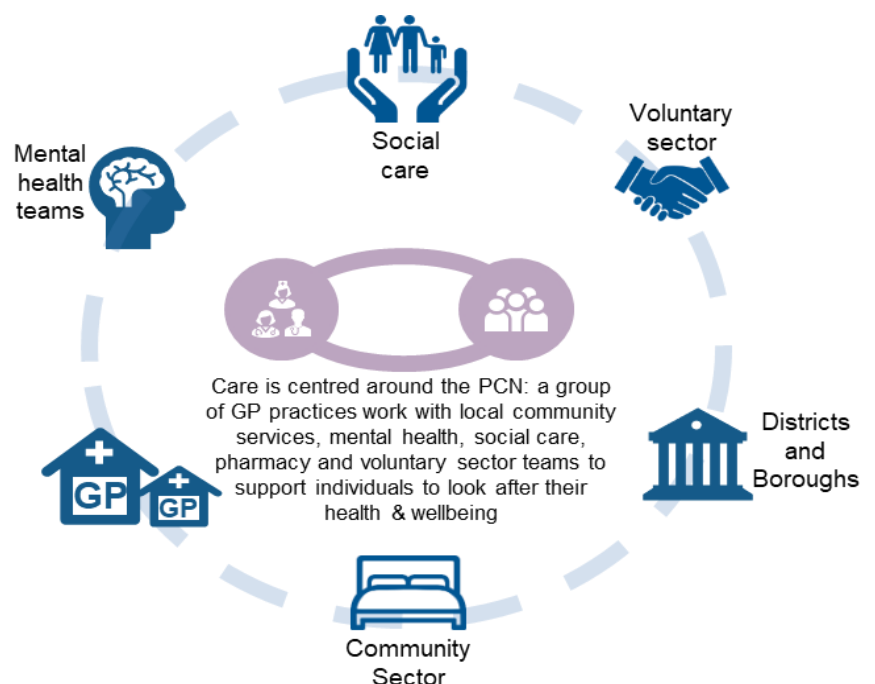
Districts and Boroughs

Community Sector

Figure 9: Neighbourhood services

---

[3] This is based on 20,000 additional staff promised to PCNs across the country through a new Additional Roles Reimbursement Scheme

Page 19 of 185

What services will be provided at this level?

Multi-disciplinary teams will provide a range of joined-up services including:[4]

- Structured medications review and optimisation
- Enhanced health in care homes
- Anticipatory care requirements
- Personalised care
- Supporting early cancer diagnosis
- Cardiovascular disease prevention and diagnosis
- Tackling neighbourhood inequalities
- Managing clinical variation
- Extended hours access to primary care
- Integrated home visiting
- Social prescribing
- Advice, support and signposting for common mental health conditions
- Palliative and end of life care.

3.2.4. Your local area

In the local area, primary, community and local hospital services will provide joined up, place-based care through Integrated Care Partnerships, at or close to home.

How will it work?

- We will redesign services around individuals' holistic needs so that they can move seamlessly between primary and community health and social care, and local hospital services in a timely and efficient manner.
- Where it is safest and most effective, we will design clinical services around targeted populations at a local area level, seeking to deliver more care at home or in the local community.
- Integrated Care Partnerships (ICPs) will take responsibility for actively planning services for the benefit of the population, segmented by health and care needs, whilst ensuring that there is not unwarranted variation in outcomes, e.g. with consistent urgent care models. This will be undertaken in close collaboration with the public.
- ICPs are partnerships of "sovereign" providers, including Local Authorities, acute hospital trusts, community services and other providers within a Primary Care Network, that deliver end-to-end healthcare. This involves optimising whole care pathways, allocating resources against outcomes for the local population, and addressing local health inequalities.
- These partnerships will lead to integrated care teams, whose composition will depend upon the need of the specific local area and the outcomes that matter to that population.
- There will be ongoing work to understand how relationships will be further built between PCNs, local commissioners and providers to effectively manage activity flows.

Page 20 of 185

What services will be provided at this level?

- Services related to **population health and wellbeing** – e.g. smoking cessation and antenatal clinics – will be tailored to local needs
- **Community health and care services** will be organised locally – including rapid response teams, reablement & rehabilitation, and other proactive approaches
- We will manage local provision of musculoskeletal, cardiovascular and falls/fragility services to **reduce unwarranted variation** in care outcomes, specifically in those areas identified in the Population Health Check
- ICPs will shift care settings to this local level where this is the best option
- ICPs will also provide a range of other functions best delivered at this local level, such as medicines management, clinical training & education, emergency planning, effective use of technology, and palliative care
- Managing demand and flow in urgent care through NHS111-CAS. This will be delivered in collaboration with ICPs to support consistency.

3.2.5. In Sussex

In Sussex, we will work in partnership to deliver high quality specialist and complex services to

improve outcomes and reduce inequality.

Figure 10: Features of Integrated Care Partnerships

How will it work?

- Complex services will be planned and managed collectively across Sussex for our population
- Our health and care professionals will work together to share best practice and deliver the best and safest care to enable our population to 'start well, live well, age well and die well'
- The Sussex system will support Primary Care Networks to manage our population's needs on a larger scale through clearly managed advice and guidance arrangements for interacting with more specialist services and a pivotal role in the networked model for urgent care
- The Sussex system will deliver better services for better value through collaborative financial management, effective financial frameworks and management of other supporting services
- Health commissioners will work closely with Local Authority commissioners to develop a programme to improve health and wellbeing, and to reduce inequalities on a Sussex-wide scale
- The Sussex system will use local data to build a single view of multiple records, in line with LHCR developments.

Working in partnership across Sussex

What services will be provided at this level?

- Clinical networks will provide clinical leadership across the region.
- Sussex has developed a consistent and strategic networked model for delivering urgent care that collaborates closely with ICPs and PCNs.
- Lower volume specialist services which require from larger population catchments and co-location will be managed and delivered at a system level across Sussex. These services include Major Trauma, Plastics and Burns, Hyper-Acute Stroke and Thrombectomy, Neonatal and Specialist Paediatric Care, Neurosciences, Cardiac Surgery and Specialist Cardiology, Renal services, some Cancer modalities and Specialist Rehabilitation.
- Clinical services such as Mental Health provision and the Local Maternity System will coordinate and set strategy at a system level to ensure high quality services across Sussex and support research and education.
- Specialist centres will continue to be developed for more complex services. This will promote collaboration between clinicians to improve the quality of care and will increase value for money through economies of scale gained from partnership working. This will accelerate the development and uptake of innovation to support our system's needs.
- System wide management of essential supporting services, including digital, workforce and estates, will deliver continuous quality improvement.
- To enjoy the full benefits of technology, all our systems will need to work together and share information. This digital compatibility will help deliver more efficient care through access to online appointments for primary care, transformation of outpatient services, and roll-out of integrated health and care records.

3.2.6. Benefits for local people and for professionals

People in Sussex will benefit from equitable access to integrated care through:

- Improved, equitable access to high quality, safe and joined-up care, e.g. through patient access routes such as NHS111-Clinical Assessment Service (CAS)
- Access to support from the health and care professional with the most appropriate skills for their specific needs
- Health and care tailored in a more personalised way, to take account of neighbourhood diversity and to maintain services at or as close to home as possible, for example supporting more personalised end of life choices
- Empowerment to improve their own health and wellbeing, to 'start well, live well, age well and die well'
- Better availability of non-clinical solutions – e.g. preventative care to improve health and wellbeing
- Access to integrated health and care records
- Easier interactions with health and care services through technology-based solutions
- Access to primary care extended hours in the evening and at weekends
- More integrated support for multiple health conditions
- Enhanced support in care homes to ensure safe and high quality care.

Professionals will benefit from more collaborative and proactive ways of working, and effective tools and processes to enable them to deliver consistent and high quality care through:

Page 22 of 185

- Greater professional satisfaction, with reduced burnout and improved retention, will help attract people to work in the NHS in Sussex
- Principles of inclusion, integrity and empowerment will be central to all activity
- Integrated and collaborative working with health and care colleagues will create opportunities for learning, uptake of innovation and providing more seamless care
- Improved health and wellbeing in Sussex, and reduced inequalities, will arise from encouraging preventative approaches across the system and empowering people to self-manage their conditions
- Professionals will have access to an integrated care record to facilitate these new ways of working
- The workforce will be adequately resourced, contain a diverse skill mix, and be sustained through effective succession planning
- Standardised systems, processes and approaches across the local area will help with delivering more consistent care
- There will be opportunities to co-design pathways and delivery of local services at scale
- Safe and positive environments will allow all professionals the freedom to speak up and to be heard.

3.2.7. Underlying principles

A set of underlying principles will guide how we deliver and organise health and care differently – in neighbourhoods, local areas and Sussex-wide.

Principle type	Principle	Rationale
Deliver health and care differently	Fewest medical miles	People prefer to have their care delivered close to home where possible. Information should flow between providers so that people do not have to travel long distances for care.
	Access to the right person or advice first time	Seeing the correct professional first time leads to quick, safe and efficient advice or treatment
	Timely provision	Services should be delivered in a timely manner that also manages demand and expectations
	Ensure appropriate movement of people across the system	When people move across providers in the system, it should only happen where necessary and should be managed effectively
Organise health and care	Reduce inequality	People, wherever they live, must have the same opportunity to lead a healthy life. To tackle inequalities, we must give more intensive support to those who are

Page 23 of 185

Principle type	Principle	Rationale
differently		at greatest risk of poor health and may need additional help to access services.
	System integration	As systems increasingly come together, we need to think beyond discrete entities and create end-to-end pathways
	Incentivise quality outcomes	Commissioning for value incentivises the delivery of high value services, measured against a diverse set of metrics co-produced with patients which reduces variation
	Maximise quality through reducing variation	For every defined intervention by a practitioner, we should maximise quality by targeting the efficient delivery of high value, evidence-based care pathways
	Digital compatibility	Digital solutions should be developed in ways that make information sharing possible across the system
	Partnership working	Health and social care working in partnership across Sussex will deliver the best quality and safety of care in a joined up environment

3.3. Public engagement

3.3.1. Public contribution to this strategy

Over the last three years, a significant amount of work has been undertaken to ensure our populations have been involved in helping to shape the planning and provision of local health and care services across Sussex. This has been done primarily through two engagement initiatives – *The Big Health and Care Conversation* and *Shaping Health and Care*. These engagement mechanisms provided people with the opportunity to discuss how services and processes could be improved, and also to highlight their experiences and issues that needed to be taken into account with future planning and organisation of services.

This feedback helped develop the local transformation plans that have formed the basis of the West Sussex, East Sussex and Brighton & Hove place-based plans in Appendices B,C and D. Additionally, this public engagement and feedback informed the development of the system-wide Population Health Check that was published in January 2019 and provides the evidence base by which this strategy has been developed.

Following the publication of the NHS Long Term Plan in January 2019, further public engagement took place across health and care organisations to ensure our communities had the opportunity to respond to the national ambitions and expectations set out in the plan and to discuss how it could be brought to life across local populations.

The engagement was badged under the title 'Our Health and Care…Our Future' and was framed under the topics that made up the FUTURE acronym:

Facing up to our challenges
Understanding our needs
Transforming our services
Unjustified differences in our care
Resources for our services
Equity for our people

Framing the discussions in such a way provided people with clear and understandable topics to discuss, and ensured that conversations could be broad and span beyond just healthcare. Our public were informed throughout the engagement process that their feedback would be used to help shape this strategy and that we wanted to build on, and not replicate, previous conversations that had taken place as part of our ongoing engagement.

The engagement was carried out in two phases. During February to May 2019, we focused on geographical locations and spoke to communities in 12 different locations across Sussex. Phase two focused on targeted engagement with individuals and groups we had not spoken to in phase one, and who historically have not had regular opportunities to input their feedback into health and care services.

In total, we had almost 1,000 conversations with people across Sussex and collated a significant amount of feedback. A summary of the key themes of this feedback and how we have responded to it is outlined below. A full summary of the feedback and how it has been used to shape the strategy can be found in additional documents.

Alongside the qualitative feedback collated, we also carried out a prioritisation exercise across our communities to gain a greater understanding of what areas of the NHS Long Term Plan our population found most important to them. The results of this are outlined below and have been used to provide greater evidence for the actions and strategic direction set out within this strategy.

Page 25 of 185
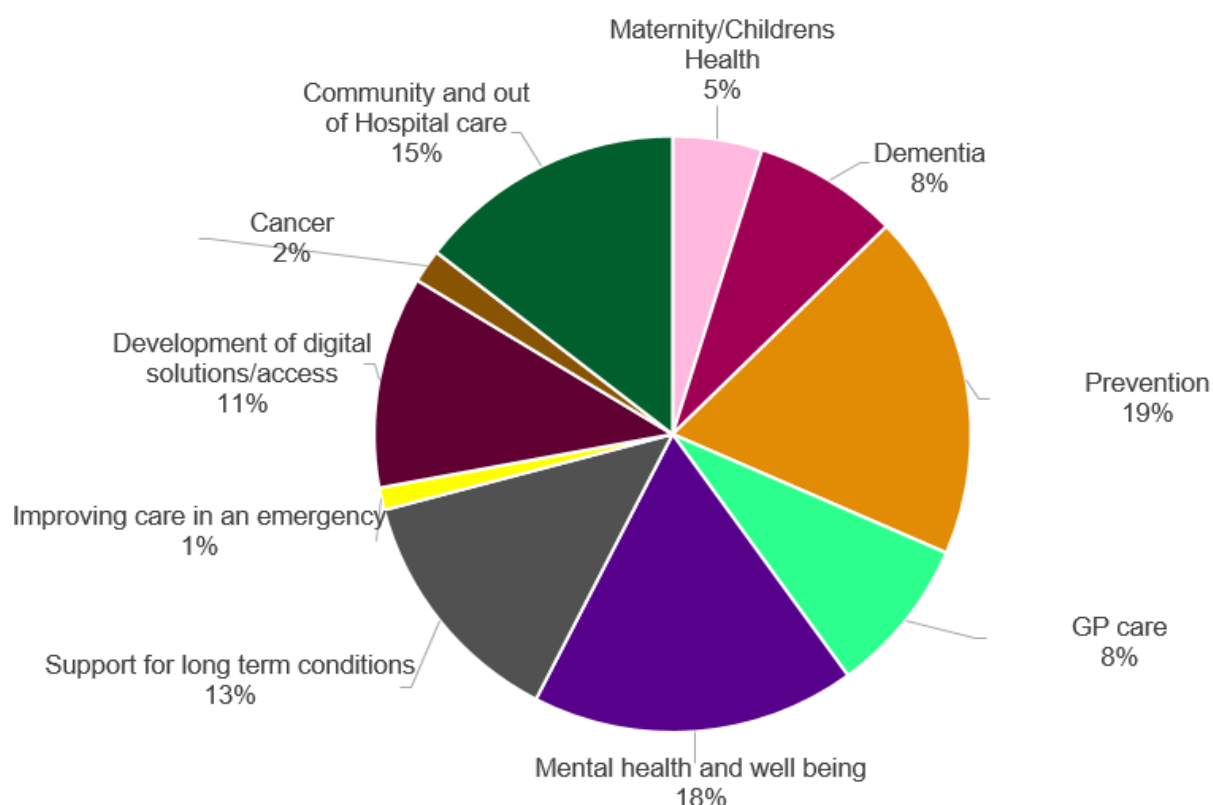
Figure 11: Public opinions on areas of the Long Term Plan most important to them

In addition to the public engagement carried out by our health and care organisations, NHS England commissioned Healthwatch to support systems to capture the views of the public living across their local areas.

Our three Healthwatch organisations, East Sussex, West Sussex, and Brighton & Hove, worked together to carry out a survey and hold focus groups to gain feedback on the NHS Long Term Plan. Almost 650 responses were received on what mattered most to people about their care and support needs. This feedback has been considered as part of the development of this strategy and is summarised in a supporting document.

Facing up to our challenges

Understanding our needs

Transforming our services

Unjustified differences in our care

Resources for our services

Equity for our people

Key themes:

- Patients should be supported to **play a more active role** in their care incl. **shared decision making**

- **Greater focus on prevention** is needed with info. available through varied routes

- **Community initiatives**, incl. social prescribing, should be seen as a viable alternative

- Moving **investment into primary and community care** will help support local provision of services

- **Holistic approach to wellbeing** should join up services incl. housing, transport, health and social care, e.g. at 'Health Hubs'

- **Mental health** should be prioritised and services improved

- **Integrated health records** are needed to enable joined-up care

- **Workforce capacity** is impacting experience of care and needs to be addressed urgently

Our response:

- Our new operating model is built with **prevention and self-management at the centre**

- Through the use of Primary Care Networks, **community and voluntary services will play a greater role** in provision of services

- Population Health Management models will help **prioritise prevention and allow funding to move to support** these initiatives

- Local health and care services are becoming **more integrated** through ICPs and **forming collaborative links to local authority** services

- **Mental health is a priority area**, with £XX investment ringfenced over the next five years

- Development **of comprehensive care records** are a priority to enable our digital transformation

- **New workforce models**, incl. new roles are being developed

Figure 12: Key themes from engagement 'Our Health and Care…Our Future'

Page 27 of 185

3.3.2. Ensuring ongoing public involvement

Our local health and care system is committed to developing a strategic model that is shaped, developed and maintained with the sustained and ongoing input and involvement of our populations. We want to create a system where public engagement and involvement is institutionalised within the functioning of our health and care organisations and fully embedded in how services are planned, provided and paid for.

To ensure this aspiration becomes a reality, during 2020-21 we will work with Healthwatch, the community and voluntary sector, and our communities, to develop a new integrated model of public engagement. This model will involve:

- A new framework for engagement that describes what good public involvement looks likes at a strategic and local level
- A new way of working across our three Healthwatch organisations to strengthen how the patient voice can be heard across the health and care system
- Mechanisms by which public feedback can be better captured and shared to inform the work of all health and care organisations across the system
- A governance framework for partnership involvement that ensures two-way engagement across our neighbourhoods, communities, places and Sussex
- An agreed framework and principles for achieving co-production, co-design and representation in a meaningful and productive way across the system
- Greater transparency and openness in the work of health and care organisations across the system and developing Integrated Care System
- Co-production of our agreed outcome sets with our populations
- Embedded public and patient involvement and engagement within our continuous improvement framework.

3.3.3. Communicating and ensuring engagement with the strategy

Date	Action	Details
28 October	- First draft published for comment on the Sussex Health and Care Partnership website - First draft of strategy shared for comment with members of the public and stakeholders who attended previous engagement events - Stakeholder letter to system partners	Feedback form will be available for comment for two weeks – closing on 8th November
2nd December	- Full final document published - Summary document published	- The document will be fully designed - The document will be written in plain English and provide a Sussex narrative for the plan - They key areas of work and changes will be summarised individually to

Date	Action	Details
	• Summaries of key areas • Easy read version • Engagement document	provide scope for discussion • An easy read version of the plan will be produced to ensure full accessibility • A supporting document will be published summarising the engagement that has taken place, the feedback themes and how they have influenced the plan
January 2020 onwards	• Communications and Engagement Plan	We are developing a full post-publication plan which will include: • Communications campaign to bring the strategy to life • Communications campaign around key business transformational work • Public, clinical engagement and co-production/design programmes

4. Transitioning to our new model

The Sussex Health and Care Partnership is a new and relatively complex footprint with many considerable strengths from which we can build our system aspirations.

Our new Health and Care Strategic Model and the guidance on ICSs, ICPs and PCNs set out in the Long Term Plan provide an opportunity for fundamental system reform. We will use this opportunity to form new ways of working and provide the bandwidth to deliver the significant number of initiatives included within the Long Term Plan.

4.1. Sussex as an aspirant ICS

Collaboration across the ICS will provide the mechanisms needed to deliver our system priorities through service and partnership development.

We have already made significant strides on our journey towards greater integration and development as an aspirant ICS. The figure below shows our current position against the five domains of the ICS maturity matrix.

	Current position
System leadership, partnerships and change capability	• System leaders signed up to working together formalised through a signed contract agreement • Clear shared vision developed by the Clinical and Professional Cabinet, with representation from all NHS providers and commissioners, public health and primary care • Transparent, collaborative governance led by the Partnership Executive Group (members from provider and commission Executives, Local Authorities and senior clinicians), a single SRO and independent chair • Core Sussex programme team funded by contributions from partner organisations
System architecture and strong financial management and planning	• Strategic model designed around delivery of services at neighbourhood, place and system level • Plans for commissioning reform in place, transitioning to 3 CCGs contiguous with local authority boundaries • System-wide plans for workforce, estates and digital infrastructure with some early implementation • History of successful joint financial management, currently transitioning to a new financial framework and system of financial assurance
Integrated care models	• Established and ongoing programme to address unwarranted clinical variation • Plans in place to transition to population health management models • Early development of a new strategic model to deliver the LTP commitments with horizontal and vertical integration
Track record of delivery	• Significant improvement in overall financial improvement from 17/18 to 18/19 with two Trusts out of financial special measures and legal directions removed from three CCGs • Widespread improvement in care quality with two providers moved out of 'inadequate' and three rated 'outstanding' by the CQC
Coherent and defined population	• Geographical footprint co-terminous of two county and one city council – developing CCGs and ICPs aligned to the boundaries of a single local authority • Patient flows not fully aligned to local authority boundaries and plans being developed to manage this

Our ambition is to become a 'maturing' ICS by April 2020, building on our strong foundation in collaborative, integrated partnership working. This system working will be supported by and further developed through the ICS Accelerator Programme that is already in place.

We recognise that significant work will be required to reach our goal and develop as an ICS, building on our considerable strengths and recent progress. Our priority areas include:

1. **Developing and embedding our new system model**; this includes our overall ICS operating model as well as the development of ICPs and PCNs
2. Reforming our **commissioning model**
3. Codifying and implementing a **Population Health Management approach** that will enable us to focus on our three building blocks of prevention, addressing the wider determinants of health and enabling individuals to better manage their own health and wellbeing
4. Supporting **collaborative delivery of the LTP commitments**
5. Building a **shared, robust financial framework and financial assurance system** (see section 5 for details).

Our future ICS will maintain an overall assurance role for the Sussex health and care system; provide a forum for leadership, strategic oversight and collective decision making; and set the strategic direction and support the operational planning required to achieve this. The ICS will continue to plan and commission specialist services collectively, using clinical networks and building on existing clinical improvement, as well as facilitating collaboration and joint planning on enabling functions including finance, workforce, digital, estates and quality assurance.

In the transition phase to becoming an ICS, priority transformation programmes will continue to be overseen and monitored at a system level. As the places transition to becoming ICPs, greater system responsibility will transition from the ICS to be managed through the ICPs, with the ICS retaining an overall assurance role.

4.1.1. Developing and embedding our new system model as a future ICS

As a future ICS, we plan to have three CCGs and three ICPs contiguous with local authority boundaries, working with neighbourhoods. Within each neighbourhood, one or more of our 38 PCNs will bring together GPs to work together with local community services, mental health, social care, pharmacy and voluntary sector teams, to provide integrated health and care for patients and the population. This will enable patients to experience well-planned services, appropriate to their needs, and seamless pathways. Together our services will ensure all individuals receive the best care in the best environment, developing new models of care at every level.

Our system reform will have to reflect the varying maturity of development within these proposed ICPs and amongst our PCNs, including the provision of additional support for organisational change and PCN development. In addition, we will need to work with our neighbouring systems in Surrey, Kent and Hampshire to ensure our planning and care delivery takes into account actual patient flows. Further detail of this support is shown in sections 4.2 and 4.3.

An overview of our system reform milestones is shown below. These are current expectations which will be confirmed once the programme is underway.
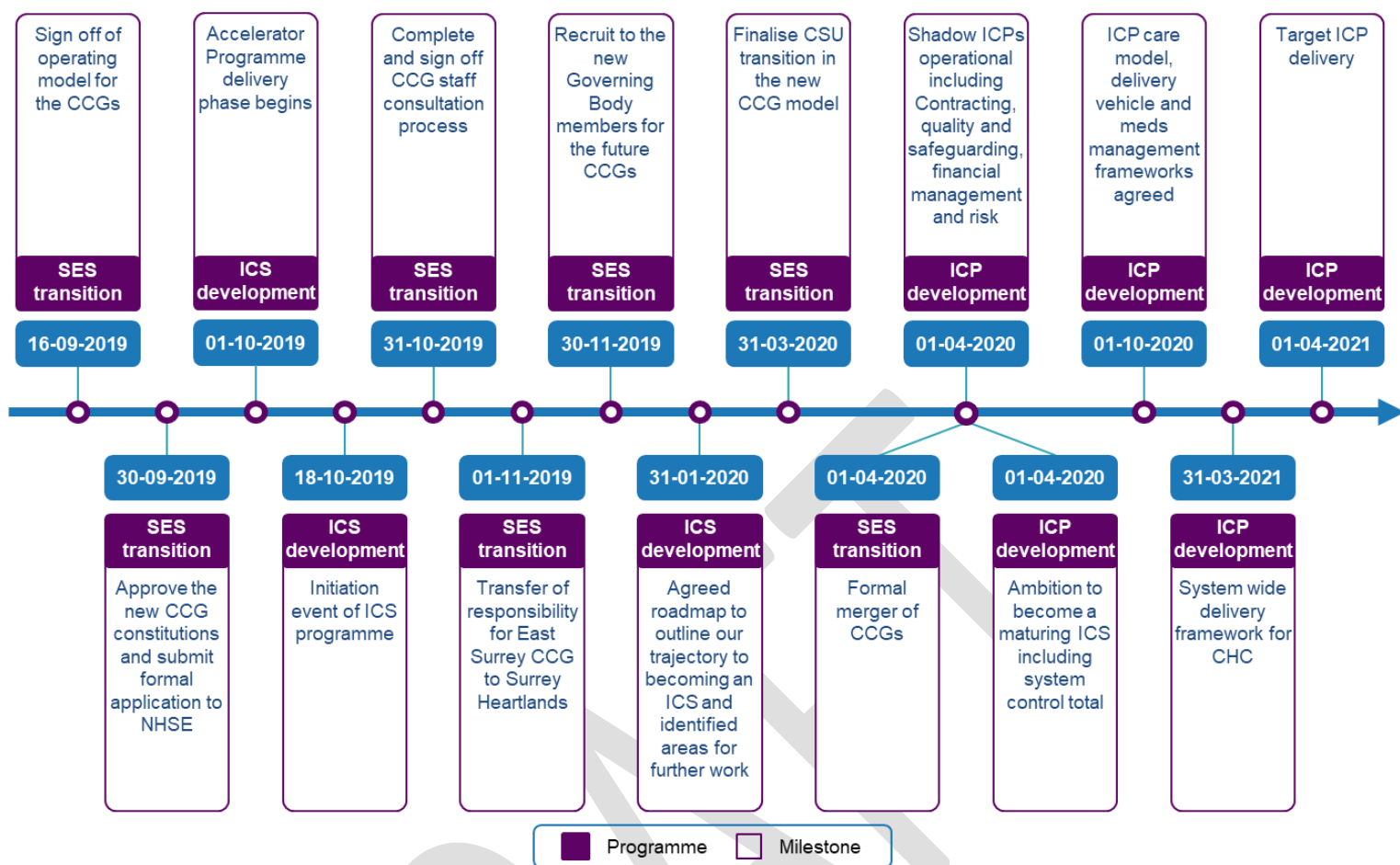
Figure 13: Key system reform milestones

4.1.2. Reforming our commissioning model

Through our Commissioning Reform Programme, we will foster collaboration between health and care commissioners, working across traditional boundaries to commission for improved population health outcomes, a reduction in health inequalities and improve collaboration and partnership working between CCGs and local authorities.

Our footprint has undergone significant change in recent months, transitioning from the Sussex and East Surrey STP to the Sussex Health and Care Partnership, following the move of East Surrey CCG and the associated providers to join Surrey Heartlands ICS in July 2019.

We have used this change as an opportunity to review our boundaries and the local commissioning landscape. Our seven CCGs have agreed to re-align to reflect local authority boundaries, becoming West Sussex, Brighton & Hove and East Sussex CCGs. The go-live date for the new, expanded CCGs is expected to be April 2020, with the application and implementation processes running from now to March 2020.

To support a smooth transition, there will continue to be a single Accountable Officer and shared executive management team across all CCGs, responsible for ensuring consistency of commissioning decisions and streamlined arrangements. Each of the new CCGs will also have a single Managing Director focused on local partnerships and delivery.

Page 32 of 185

Working in partnership across Sussex

4.1.3. Codifying and implementing a Population Health Management approach

Population Health Management (PHM) has been recognised in the NHS Long Term Plan as key to delivering a sustainable health and care system and improving the lives of the population.

New data analytic tools and digital technologies are helping make PHM a reality, by helping to identify risks and stratify patient populations, improving the speed and accuracy of diagnostics, and designing personalised treatment plans. Successful implementation of PHM requires a combination of:

- **Behavioural change** from both health care providers and patients to focus on prevention, with support to self-manage and population segmentation tailored according to the individual's Patient Activation Measure, utilising an array of analytics, technologies and communication tools
- **Proactive identification and monitoring of high-risk patients**, and equitable access to evidence-based medicine, focusing on prevention and treatment and on improving function and wellbeing for individuals
- **Realignment of funding flows and incentives** to encourage staff to work differently across care settings, underpinned by an appropriate outcomes framework.

Our emerging approach to PHM is described in the figure below.
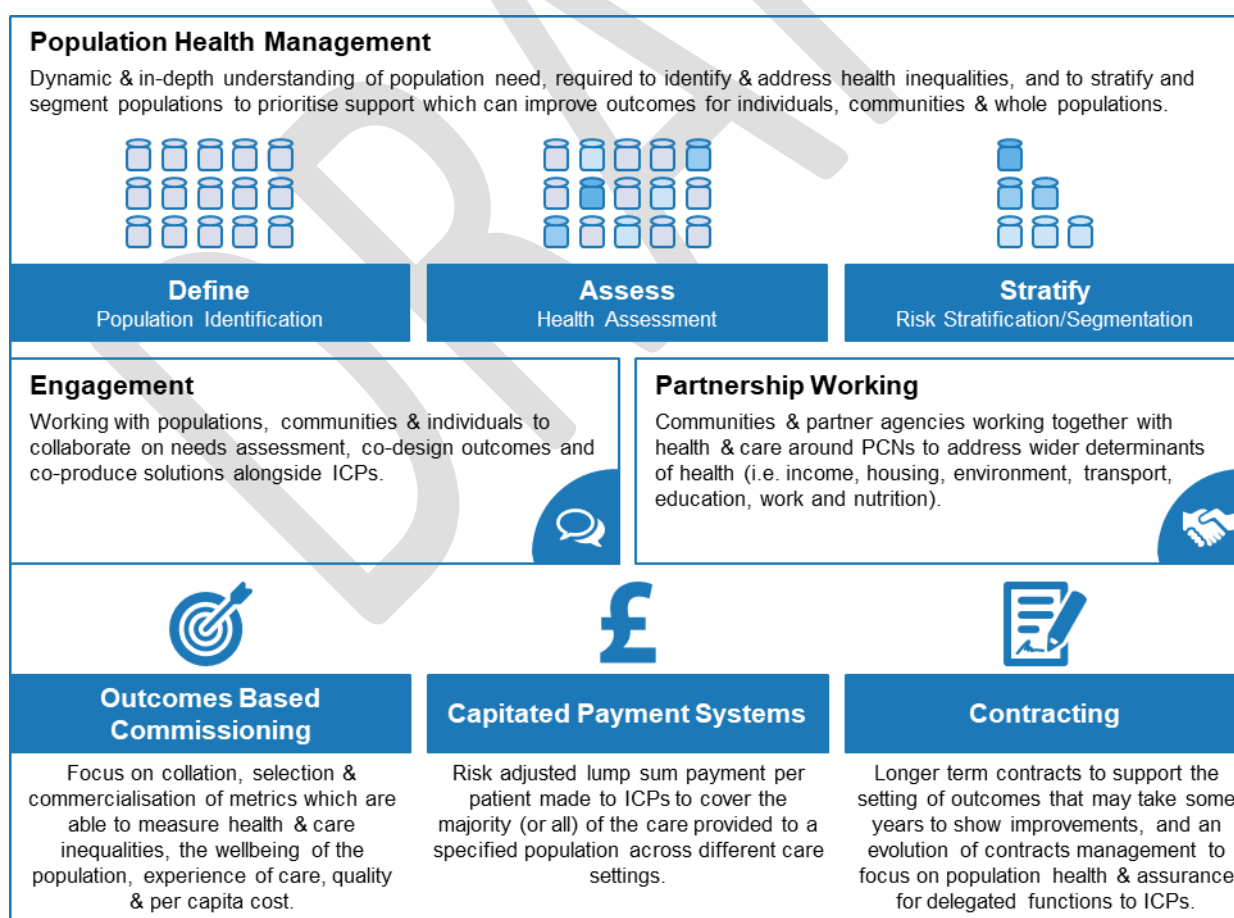
Figure 14: Our emerging approach to population health management

Moving to a PHM approach is dependent on the change capabilities within local systems.

Places and neighbourhoods will need to be supported to roll-out PHM tools to identify groups at risk of adverse health outcomes and inequalities, and to plan services accordingly.

The Sussex Health and Care Partnership will develop two frameworks in 2019/20 to assist partners in understanding the steps needed to implement an effective PHM approach:

1. **Population Health Maturity Assessment Framework**. This will address overall system maturity and enabling factors such as system leadership and governance, culture and engagement, data and analytics, technology, and financial and organisational models

2. **Population Health IT and Data Analytics Framework**. Technology underpins success for PHM systems, and it is important that the correct IT and digital infrastructure is in place to support PHM roll-out.

4.1.4. **Supporting collaborative delivery of the LTP commitments**

Our new strategic model is designed to facilitate ongoing service improvement and transformation. As a starting point, we will work to deliver the substantial number of commitments set out in the Long Term Plan alongside our local priorities, as described in section 7.

Many of these transformation priorities will be planned and delivered at the place-based level. To support and supplement this planning, we are collaborating with established clinical networks (e.g. the Local Maternity System) and developing system-level partnerships that target specific improvement areas. Across our footprint, we will make use of partnerships and clinical networks to ensure that clinical leadership is the cornerstone of system development. Over time different networks will be developed to address key system issues and the function of these will be agreed by the Partnership Executive.

One such partnership is our Acute Collaborative Network, which is described in more detail below.

Our Acute Collaborative Network

The four acute providers across Sussex have established a Sussex Acute Collaborative Network to:

- Strengthen the strategic partnership between organisations
- Ensure ongoing collaborative working in the development and delivery of sustainable models of care
- Oversee, coordinate and help a programme of work that requires input from across the system and aligns with the strategic priorities of the Partnership.

Initial priority areas for improvement, including Head and Neck (including OMFS and ENT), Dermatology, and Adult Burns, have been agreed by the Sussex Health and Care Partnership Executive. In addition, the Acute Collaborative Network is undertaking a prioritisation exercise to identify and agree further workstreams where collaboration between acute providers within Sussex could deliver improvements in services for the Sussex population, support providers' individual clinical and financial sustainability, and that of the Partnership.

Priority workstreams will be those that require providers to collaborate and determine an optimal way to transform provision and deliver benefit to the Sussex-wide population. The network will be responsible for developing proposals for service transformation and reconfiguration, bringing together providers and facilitating engagement with commissioners, system partners and the public to refine and deliver optimal services.

3Ts Development

The major development of the Royal Sussex County Hospital site (the 3Ts development) provides a significant and exciting opportunity to develop services in Sussex for the benefit of patients locally. As set out in the 3Ts Business Case, there are opportunities to develop Neurology and Neurosurgery services so that Sussex patients no longer need to travel to London for their care. There are further similar opportunities to strengthen tertiary care , such as Cardiac Surgery, specialist Stroke services and the co-location of Burns care on the Major Trauma Centre site. The Sussex Acute Collaborative Network will explore and promote these and other areas to maximise the benefit of the 3Ts development.

4.2. Establishing place-based Integrated Care Partnerships

The Sussex Health and Care Partnership will consist of three places, contiguous with local authority boundaries in Brighton & Hove, East Sussex and West Sussex. Each place is responsible for population health management and commissioning, and for delivering joined-up health and social care for its local population, which will be provided at or as close to home as possible.

To achieve this, each place will establish new community and prevention-based models of care, aligning providers to deliver: seamless end-to-end patient pathways in a timely and efficient manner; integrated population health and care commissioning; and partnership governance arrangements, including the development of an Integrated Care Partnership to mirror the population health and care commissioning footprint.

Key service transformation priorities for places include:

1. Supporting development of PCNs
2. Transforming out of hospital care and fully integrated community-based care
3. Reducing pressure on emergency hospital services
4. Reducing waits for planned care
5. Giving people more control over their own health and more personalised care
6. Supporting digital transformation of primary care and outpatients
7. Ensuring a strong start in life for children and young people
8. Improving prevention and care for respiratory conditions
9. Shifting care settings to the place-level where this is the best option.

Detail on each of the place-based delivery plans can be found in Appendices B – D, and common principles are outlined in section 7 below.

To enable their development and maturation, the places will need to develop a number of elements which are detailed in the remainder of this section.

4.2.1. Integrated Care Partnership agreements

Each place will be responsible for developing an Integrated Care Partnership. These will function as partnerships of sovereign providers that:

- Deliver end-to-end healthcare
- Coordinate care planning, management and integration to address the wider determinants of health
- Model and manage care delivery including developing operational plans, optimising whole system pathways, and allocating resources against delivery of contracted outcomes
- Manage and evaluate quality and performance, and ensure delivery of constitutional standards
- Provide services that are best delivered on an ICP footprint, such as medicines optimisation, clinical training and education, and emergency planning, supported by effective use of technology.

This Partnership will include local authorities, acute hospital trusts, commissioners, community services, mental health providers and other providers within a neighbourhood, as well as representation from the voluntary sector.

It is proposed that ICPs are developed and delivered in three phases across 2019/20 and 2020/21. These phases will be as follows:

- **Phase 1 – Establishing the programme**. Partnership principles, definition, scope, partnership agreement to support development of the ICP.
- **Phase 2 – Programme planning**. Detailed programme plan, leadership and governance arrangements, financial and risk management.
- **Phase 3 – Partnership development**. Collaborative service design, quality and safeguarding frameworks, primary care development, contracting framework, ICP delivery vehicle, workforce development.

4.2.2. Place / ICP infrastructure and governance

Each place will require a shared leadership agreement regarding the establishment of the necessary governance, assurance, contracting, performance and financial management to support partnership working.

Delivery and planning will be coordinated and overseen by an ICP Board and a named SRO, who will report on progress to, and be held to account by, the Partnership governance. The Partnership will retain responsibility for regional strategy and assisting ICPs with developing capacity at a place-based level. The ICS will also serve as an intermediary between national and regional NHS entities, providing a mechanism to align regulators to support integration at the local level.

Each place is currently developing their own governance structure, with ultimate oversight sitting with a place-based Board. Each place-based plan sets out what specifically statutory partners are going to deliver to improve outcomes for individuals and the wider population, and will provide the guiding framework for accountability.

Page 36 of 185

4.2.3. Outcomes-based commissioning and population health management

Commissioning and prioritisation decisions will be based upon the Partnership's population health management model, seeking to address the themes identified in the Population Health Check as well as the needs of local communities.

Each place will implement a clear outcomes-based commissioning framework in partnership with CCGs and local authorities. These frameworks will be developed in collaboration with the Partnership and based on the outcomes identified as important by the local populations.

To support this, we will change the way we assure financial performance and align this to a population health management approach.

For example, a significant proportion of contracts are already aligned incentive contracts for 2019/20 and we are exploring risk-sharing models to drive changes for patient cohorts. This could include a risk-adjusted capitated payments approach for long term contracts with ICPs to cover the majority (or all) of the care and support provided to our population across different care settings.

The 'place' levels provide sufficient scale to operate one or several risk bearing contracts, since risk can be spread across providers and improve cost forecasting with a larger population base. Our payment models will need to incentivise the system to deliver our new models of care, and the system is committed to identifying innovative and risk-sharing options to engage both providers and commissioners.

4.2.4. Local authority partnerships

Each place is working to strengthen engagement with local authority partners for integration of care and population health and care commissioning. This will include regular scheduled meetings with senior local authority leads to continue to improve working relations, and partnership with the local authority delivery functions.

4.2.5. Communications and engagement

We will develop a framework to ensure ongoing engagement with communities, staff and other stakeholders with regard to the impact of integration on care and to support a co-design approach to the development of services. Our partnerships will be focused on inclusivity and equity, with an unequivocal focus on addressing the wider determinants of health.

4.2.6. Current state

Current place-based structures have established good collaborative working between system partners, and these relationships will form the foundation for the transition to ICPs.

Our achievements so far include:

1	Aligned incentives contracts agreed with BSUH, ESHT, & WSHFT	
2	Outline programme plans established at place level and aligned to key outputs & milestones for wider system reform programme	FUTURE
3	Establishment and/or re-establishment of partnership infrastructure at place level to support ICP development & delivery of SHACP business plan	
4	Definition, primary functions & outcomes and high level model for ICPs at place level established for SHACP executive against an outline population health model	
5	High level model established for place-based partnership infrastructure including roles & responsibilities for SRO at place level, the programme management infrastructure & the programme board	
6	Framework for shaping footprints for ICPs provided at place level supporting decision making at SHACP executive	

System Reform Objectives

To secure outcomes set out within the framework of the strategic intent paper agreed by CCG GBs in March 2019.

To ensure that agreed system reform changes are delivered in line with the strategic intent and, wherever practicable, at place.

To champion the change and to ensure that the public, staff and other key stakeholders are engaged with and supported through the transition.

All Integrated Care Partnerships operational by April 2022

Figure 15: ICP transition achievements

4.2.7. **Next steps**

In order to facilitate this, the places are aiming and being supported to:

- Engage and co-produce with patients and the public, detailed care delivery models to address inequities of access and ensure new services meet the local needs
- Work in partnership with local neighbourhoods and PCNs, supporting PCNs to bring together GPs to work together with local community services, mental health, social care, pharmacy and voluntary sector teams, to provide integrated health and care for patients and the population, at the neighbourhood level
- Manage and evaluate ongoing quality and performance, including regulatory compliance and delivery of constitutional standards.

4.3. Neighbourhood-based Primary Care Networks

Primary care plays a pivotal role in the NHS, being the entry point for the prevention and treatment of illness. However, it currently faces unprecedented pressure, due to increasing patient numbers, patient needs and workforce challenges. Traditionally, primary care was defined as general practice, community pharmacy, dental and optometry services. Nowadays, though, the scope and delivery of primary care is much wider, incorporating appropriate self-care interventions, mental health support, community health care teams and multidisciplinary care.

A great deal of progress has been made by the Sussex CCGs in supporting general practice to increase the resilience and sustainability of vulnerable practices, and in implementing the

Page 38 of 185

ten 'High Impact' changes set out in the General Practice Forward View to improve efficiency and resilience, and work continues across these areas. The Long Term Plan now provides the mandate to build on this foundation and our plans to date, in the delivery of integrated primary and community care.

There are strong examples of integrated care already in place across our CCGs and, over the last 12 months, work has begun to identify best practice from our urgent care, planned care, care home and frailty pathways and locally commissioned services. This will help us establish a baseline, build on the learning, and develop plans that support the continuation of work at scale to progress and develop care close to home, supported by the integration of general practice, voluntary, community and social care.

More recently, work has focused on the establishment and development of Primary Care Networks across Sussex, in preparation for PCNs to work in partnership with and be supported by all key health and care partners across the system as an ICP.

Under our new operating model, a greater proportion of services will be delivered in neighbourhoods close to the individual's' home, shifting activity from acute to community and primary care services. This shift will be facilitated by the development of Integrated Care Partnerships (ICPs), bringing together teams from general practice, community services, social care, pharmacy and the voluntary sector to design and deliver integrated pathways of care and local services in neighbourhood-based Primary Care Networks.

To support this transition, CCGs are developing a programme of work to support PCNs to develop, mature and therefore be prepared and able to contribute to and work with community care providers in an ICP.

Over the next five years, we will work with the PCNs across our footprint to deliver these new models, working within three core areas:

1. **Service transformation and improvement within primary care** to support practices to deliver a consistent, accessible and high quality service
2. **Formation and development of effective PCNs**, setting up the core structures and processes needed to enable our PCNs to deliver as mature organisations
3. **Delivery of the new network specifications** and the commitments of the LTP.

4.3.1. Current state and context

Within the Sussex footprint, there are 178 GP practices, of which seven are Care Quality Commission (CQC) rated 'Outstanding', 161 'Good', six 'Requires Improvement' and four 'Inadequate'. The practices vary in size, the smallest registered list being c 1,400 people and the largest c 25,000, and are organised into 38 Primary Care Networks, covering 100% of our population. All our practices participate in The Quality and Outcomes Framework (QOF), with good achievement of between 93.5% - 100% in 2016/17.

Over the last five years there have been a number of practice closures and mergers as a response to retirement of partners and salaried GPs, and the introduction of general practice at scale. The Sussex STP is facing continuing workforce challenges across primary and community services caused by well-documented workforce shortages across many professions. The GP workforce in Sussex is similarly challenged, with many practices adopting a broader multidisciplinary approach to care delivery to manage patient demand

Page 39 of 185

and increase capacity.

4.3.2. Service transformation and improvement within primary care

High quality, resilient and accessible general practice is essential to the delivery of responsive and integrated care. A key focus of the CCGs work programme is to continue to support general practice in tackling their core existing challenges and pressures, to create sustainable primary care.

Under the GP Five Year Forward View, funding for four programme areas has been allocated to support transformation within general practice, with a phased delivery plan underway. There are a number of other workstreams, enablers and plans also proceeding to support primary care, PCN and ICP sustainability and development, some of which have been described in other chapters pertaining to ICPs, integrated urgent care, digital and workforce plans.

Detailed operational plans are in place to support delivery, and a high level summary of some of the ongoing work in each area is shown in the figure below:

Work Programmes	Outline plans
GP resilience	• Standardise processes, policies and investment approach, targeting the most challenged practices to improve resilience and supporting vulnerable practices at risk of closure • Standardise our Vulnerability matrix / Quality Assessment tools • Continue to support vulnerable practices and re-purpose the primary care commissioning team to become more externally focused, to better support general practice and PCN • Continue to provide dedicated CCG support to individual practices and PCNs, working closely with LMC and lead clinicians • Adopt a single approach to practice performance reviews and membership engagement through GP and Practice Manager forums
GP retention	• Review the GP and wider primary care team recruitment and retention initiatives developed by each of the Training Hubs in Sussex and adopt the successful programmes • Continue to develop portfolio career opportunities for GPs targeting ST3s, locum GPs and GPs leaving the profession • Develop GPwSI posts in mental health • Further develop GP Fellowships which include more flexible arrangements tailored to the needs of the individual GP • Support PCNs in the recruitment of the Additional Roles and Reimbursement Scheme (ARRS) with the development of social prescribing, pharmacists, and first contact practitioner, paramedic practitioner and physician associates roles
Reception and clerical	• CCG PCN leads continue to support practices and PCNs to share best practice, identify, and source training opportunities

Work Programmes	Outline plans
training	for general practices' reception and administration teams • Assist in the availability of workflow optimisation programmes, medical terminology training and enhanced reception and clerical staff training
Improved access	• Support the delivery of extended hours as part of the PCN Directed Enhanced Service (DES) requirement • Ensure delivery of the Improved Access (I/A) national specification requirements • Work with Urgent Care Centers (UCC) and Urgent Treatment Centres (UTCs) to connect I/A service with UCC • Work with PCNs and providers to prepare for and deliver the new national Extended Access specification when released to 100% of the PCN population

Digital Programme	• Board and Primary Care Digital group in place to provide governance and consistency across the STP
	• Project methodology compiled across the STP footprint to enable consistent prioritisation to take place for all digital developments
	• On line consultation:
	• Continue with the roll-out of online consultation in Eastbourne, Hailsham and Seaford CCG (EHS) and Hastings and Rother CCG (H&R) to all practices
	• Audit and evaluate the effectiveness of the programme
	• Deliver the procurement plan to implement online consultation in the remaining five Sussex CCGs, starting in October 2019
	• Digital First – funding has been received from NHS England to support the development of four areas:
	   o Promote and enhance the digital skills of our local population and GP practice workforce.
	   o Develop an intuitive GP online resource portal, providing referral and pathway information (for health professionals) and supporting the development of PCNs.
	   o Support the use of the NHS App as a digital health and care front door for East Sussex, so people have one place to access information, advice and support. Further information on our targets for this is set out in the Strategic Planning tool.
	   o Enhance clinical engagement and leadership in digital programmes.
	   o Support PCNs to with the intraoperability of their clinical systems.

Estates / Estates and Technology Transformation Fund	• Prioritisation database compiled across the STP footprint to enable consistent ranking to take place when considering service needs and potential new developments

Work Programmes	Outline plans
(ETTF)	• Primary Care Premises and Estates group established to provide governance across the STP, with representation from all CCGs, NHSE/NHS Improvement, NHS Property Services, mental health, community trusts and other system partners • A number of new builds and refurbishment developments underway and at differing stages of planning and build • All new developments include community services and use new technology to enable efficient ways of working, e.g. video consultant appointments and Skype consultation
Locally commissioned services	• Work programme underway to review all locally commissioned services (LCS) across Sussex, to establish a baseline of LCS and standardise approach where appropriate • Approach and principles developed with LMC

PCN 7 national specifications	• CCG PCN leads to work with each PCN to ensure they are prepared to deliver the national service specifications:
	• **2020/21**
	  o Structured Medicines Reviews and Optimisation
	  o Enhanced Health in Care Homes
	• **2020/21 onwards**
	  o Anticipatory Care requirements
	  o Personalised Care
	  o Supporting Early Cancer Diagnosis
	• **2021/22 onwards**
	  o CVD Prevention and Diagnosis
	  o Tackling Neighbourhood Inequalities

LTP requirements relevant to primary care & ICPs	• Contribute to the co-design of the ICP plan and implement the LTP requirements linked to primary and community care

4.3.3. Formation and development of PCNs

Across the Sussex footprint, the 38 PCNs are in various stages of maturity and have different levels of ambition and aspiration. All PCNs have been given access to the following:

- Data packs to assess the health needs of their populations, including understanding where health needs and inequalities exist for their patients
- Additional CCG staff resources and funds to assist in their formation and development
- Information about resilience and how practices within the networks can be supported to become and remain resilient.

During November 2019, each PCN will self-assess against the NHSE PCN Maturity Matrix. The findings will be built into a PCN and Clinical Director development programme which will

Page 42 of 185

be informed by the national development prospectus and designed jointly by CCGs, PCN CDs, NHSE and the LMC. This will be nationally funded and will include:

- Access to support to develop the Clinical Director role
- Clarity about the support the CCGs will offer to PCNs in terms of resource
- Access to legal advice and support to allow development of services to be underpinned by robust governance
- Support for the development of vanguard PCNs to test and take forward functional delivery, sharing best practice as it is developed.

In addition, and to further support PCNs to move at pace, ahead of the national minimum requirements, an accelerator programme has been offered to PCNs to drive progress, support the desired integration of services, and reduce clinical variation across the Sussex STP foot print. The aims of the programme are shown in the figure below.

Progress faster	• Support a small number of PCNs across Sussex who want to develop faster in 2019/20, and deliver more than the minimum national PCN specification requirements.
Integration	• Test out how PCNs and local health, care or voluntary sector providers can come together to better integrate and transform care and services for their local population with PCNs as a key part of the local transformation approach.
Clinical variation	• Identify and demonstrate how practices in the PCN can come together to enable local transformation and delivery of elements of the SES STP clinical variation programme and/or LTP ambitions in their PCN to improve population health.

Figure 16: PCN accelerator programme aims

As part of the accelerator programme, PCNs will be asked to deliver against four core areas of focus and will have additional resource made available to support this. The areas of focus for PCNs are:

- Developing and accelerating the PCN to progress at pace, mature and deliver its ambition
- Delivering/testing out in the PCN the Sussex STP Clinical Variation Programme ambitions and requirements (Musculoskeletal falls, Diabetes and Cardiovascular disease)
- Delivering the requirements of the LTP (including anticipatory care, personalised care and early diagnosis for cancer)
- Integrating joint working of the PCN with other providers to better support integrated care and MDTs, improve the PCN population's health, and better integrate urgent or

planned care pathways to improve system flow, avoid admission and improve value for money.

4.3.4. Delivery of new service specifications

The Primary Care team are supporting PCNs to develop delivery plans detailing their ambitions and aspirations to improve their PCN population's health, and to deliver the DES, GPFV and LTP requirements.

In line with the timescales set out in the GP contract reform, PCNs will start to deliver core services from Year 2, including Enhanced Care in Care Homes, anticipatory care and medicine optimisation for target groups. Our ICPs will work in conjunction with PCNs to develop detailed operational delivery plans to each of these commitments, to meet the national deadlines and targets. Each place has been developing pilots to support their development of their PCNs.

4.3.5. Programme management

A roadmap of PCN development is shown in the figure below.

Year 1 (2019/2020)
- PCNs agree Network Agreement/Data Sharing Agreements and appoint Clinical Directors June 2019
- Delivery of Extended hours DES July 2019
- PCNs deliver new service specifications (Structured Medicines Review and Optimisation; Enhanced Health in Care Homes) July 2020
- ARRS posts (Social Prescribing and Clinical Pharmacists) in place July 2019 to March 2020
- PCN accelerator programme in place September 2019
- PCN population profiles provided November 2019
- Plans received for year 2, including appointment of ARRS posts December 2019
- Readiness to work as a provider of services assured February 2020
- Review and evaluation of PCN accelerator programme March 2020

Year 2 (2020/2021)
- Delivery of the combined Improved Access and Extended hours to PCN populations April 2020
- STP Operating Model implemented to align staff to support PCNs and integrated care, in preparation for the development of fledgling ICPs (with PCNs as active partners) Q1
- PCNs deliver new service specifications (Anticipatory care requirements (jointly with Community Services); Personalised Care; Supporting Early Cancer Diagnosis) April 2020
- PCNs deliver new service specifications (Structured Medicines Review and Optimisation; Enhanced Health in Care Homes) April 2020
- Partnership facilitate conversations with all providers so that PCNs are in a position to bid for services as an integrated care provider, with other organisations Q2 and Q3 (potential for Accelerator site to go earlier in Year 1)

Years 3-5 (2021- 2024
- Further ARRS posts in place
- PCNs deliver new service specifications (Cardiovascular Disease (CVD) Prevention and Diagnosis; Tackling Neighbourhood Inequalities) April 2021
- Integrated Care System (ICS) in Place, comprised of ICPs, delivering services to the population
- Evaluation of PCN development and transformation
- Completion of deliverables in years 3 – 5 will be worked as part of the Autumn 2019 submission of the Partnership response to the LTP and form part of this strategy – September 2019
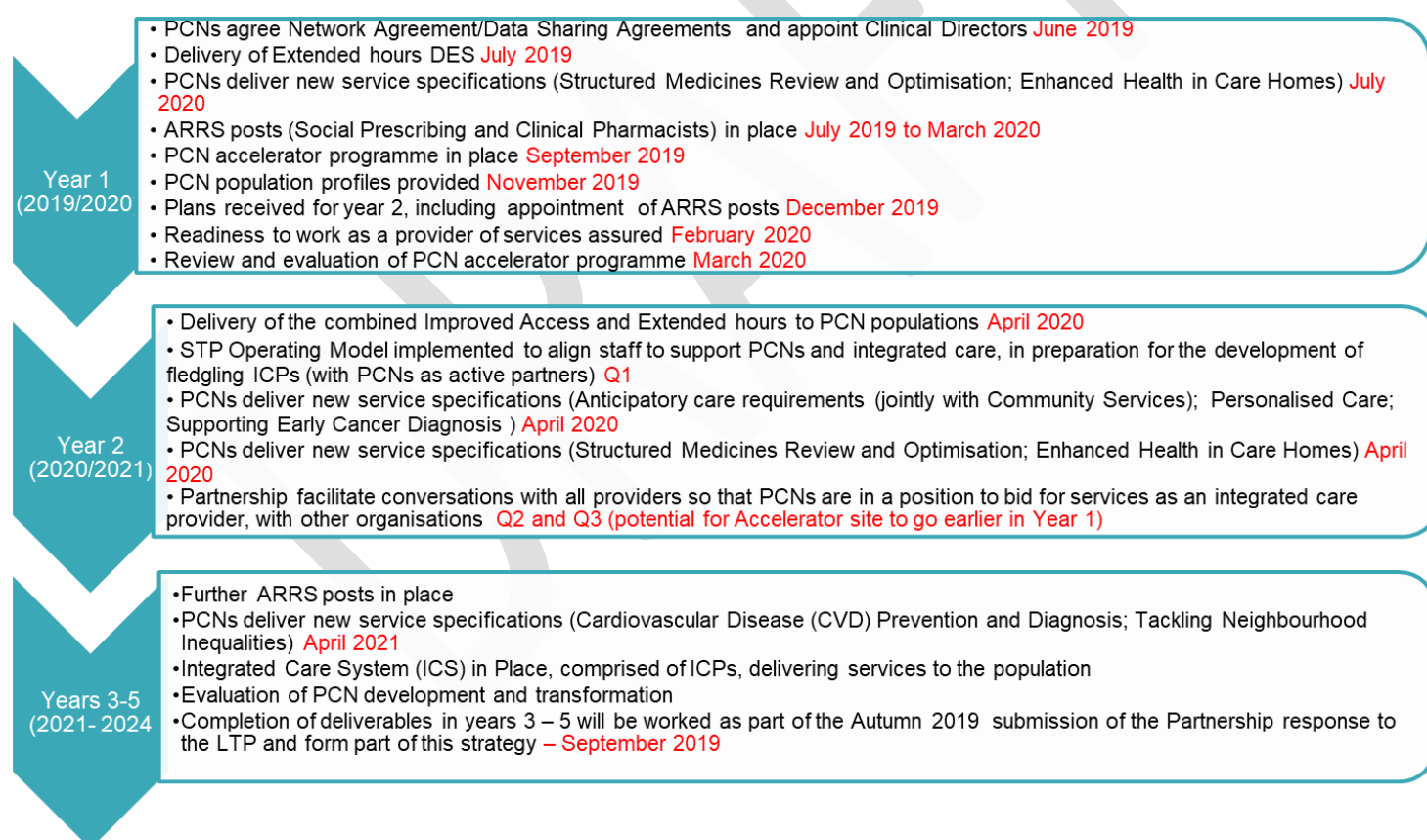
Figure 17: PCN development roadmap

The local governance arrangements for this programme, and how they align to existing CCG and Sussex governance, are set out in the diagram below. A Primary Programme Board, chaired by a CCG Lay Member for Public and Patient Involvement, is established across Sussex to provide coordinated strategic leadership and oversight of the GPFV, PCNs and new models of care and integration.
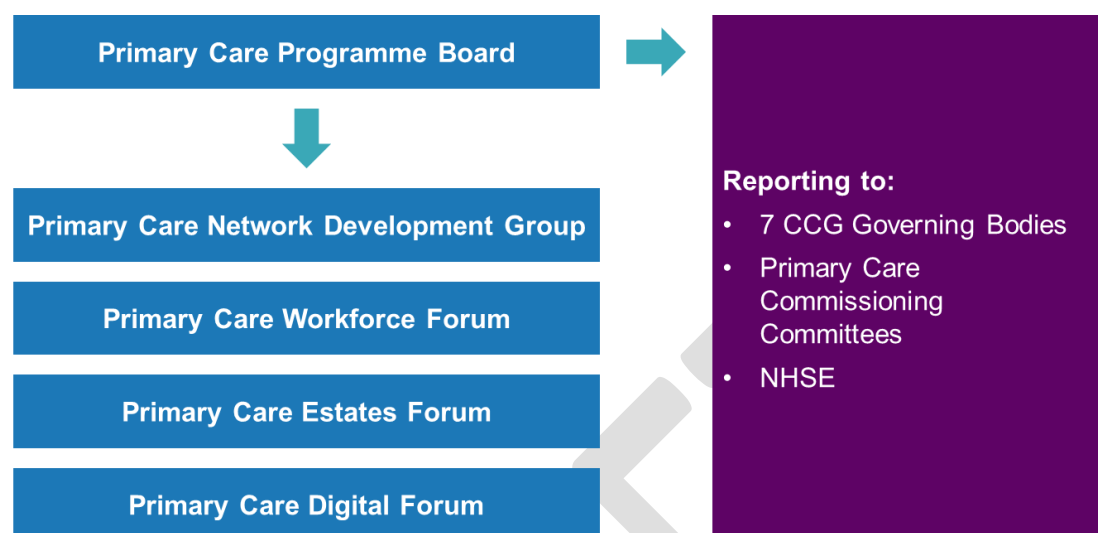

Figure 18: PCN governance

4.4. **The role of Specialised Commissioning**

Specialised Commissioning will build on the opportunities provided by our transition to an ICS by ensuring specialised services are planned and delivered as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.

As a future ICS, we will work with Specialised Commissioning to plan specialised services alongside locally commissioned services, providing the opportunity to transform and improve clinical engagement across integrated whole system pathways and positively influence health outcomes. The end-to-end integration of pathways will deliver benefits to patient outcomes and experience, reduce unwarranted variation and improve value for money. Investment in prevention and management during earlier stages in the patients' pathway should deliver a reduction in demand for some specialised services, and an integrated approach will enable services to be more responsive to the needs of the local population.

Specialised Commissioning will continue to identify opportunities for collaboration by aligning work programmes, using existing forums as a vehicle for considering these, with reference to service reviews and procurements. Where required and appropriate, services will be redesigned at a system or broader level to maximise clinical efficiency and financial resources, and to provide opportunities to align improvement programmes through joint planning and contracting.

To support the integration of specialised services into the ICS, the Partnership and Specialised Commissioning will work together to develop a roadmap to achieve devolution of commissioning of appropriate services. We will implement a framework to enable us to make decisions collectively on specific local arrangements, whilst ensuring that any proposed model of integration remains within the existing legal framework. This will be set in the

Page 45 of 185

context of the wider system architecture for those services which span more than one ICS population.

 The framework requires further development but is likely to be made up of the following:

- National parameters within which ICSs can take on more responsibility. This will clarify the extent of the responsibility that ICSs can have for specialised services, and the ongoing role of our corporate and regional commissioning teams.
- Principles to support decisions on which services can be in scope.
- Readiness criteria that ICSs should meet before taking on more responsibility for specialised services.
- Governance arrangements for signing off proposals.

Specialised Commissioning has agreed to make team members available as a resource for ICS teams. We will work in collaboration to ensure quality and compliance with commissioning standards, and look to repatriate services currently being provided outside the system closer to home where this is both in patients' best interests and supports sustainability of system providers, for example, ensuring funding transfers are secured.

5. **Investing to deliver change: our financial framework**

5.1. **Our route towards financial sustainability**

Note: this section reflects the system position as at Friday 18th October. Under the guidance of Finance Group, the system is still working on its financial planning. The current placeholders highlighted in yellow in this narrative will be finalised following a meeting of the Finance Group on Monday 28th October, in time for the 1st November LTP regional submission.

The system has recently achieved a significant improvement in its overall financial position against a trend of national decline. The aggregated outturn for NHS providers and commissioners across the system, including sustainability funding, improved from £(229.2)m in 2017/18 to £(49.5)m in 2018/19.

Nevertheless, financial challenges remain. The current forecast outturn for 2019/20 is a deficit of £(74.4)m post-sustainability funding, or £(169.8)m pre-sustainability finding. Our system-wide "Do Nothing" modelled scenario projects a pre-sustainability funding deficit of £(284.5) by 2023-24.

Summary of plan relative to NHSE/I improvement trajectories

The system has been set a trajectory of improvement to £(103)m (excluding NHSE&I funding) by 2023/24. We do not have a plan to acheive that as a system. The overall trajectory is an aggregation of targets for individual organisations. The trajectories are based on the control totals set for 2019/20. Queen Victoria Hospitals (QVH) and Crawley and Horsham and Mid Sussex CCGs do not have plans to meet those 2019/20 control totals. There is, therefore, a planned gap from the outset which cannot be bridged by a system already delivering savings which are significantly higher than national assumptions.

QVH is not in a position to sign up to its trajectory because of a £7m gap between 2019/20

Page 46 of 185

plan and control total, together with additional pressures likely to impact in-year. Over the past couple of years, it has become increasingly clear that QVH, as the second smallest trust in the country, has experienced challenges in maintaining clinical and financial sustainability. In 2018/19 the trust reported a £4m deficit. In May 2019, in agreement with the regulator and commissioners, a Programme Board was established to consider the future of QVH. Since then, a case for change has been agreed and work has begun on an options appraisal/critical success factors; this process will take time and there are limited short term opportunities to deliver savings. The publication of the Long Term Plan supports the timing of the consideration as to where QVH sits in the redesign of patient care.

Crawley and Horsham & Mid-Sussex CCGs together face a £7.6m gap between 19/20 plans and control totals alongside likely additional in-year pressures of £22m. This creates a gap from the 20/21 financial target in the region of £30m. There is no short term recovery plan for these CCGs and they are therefore unable to develop a financial plan which would meet the trajectories.

Placeholder for cross-system narrative in collaboration with Surrey Heartlands to explain collective actions guiding North ICP recovery approach.

Placeholder for potential risk associated with WSHT/Coastal West Sussex CCG

Compliance with funding guarantees

The system is fully compliant with the requirements of both the Mental Health Investment Standard and the Primary Medical and Community Services funding guarantees.

Approach to efficiencies

The system has planned to meet the national requirements to include 1.1% savings for providers, another 0.5% for those in deficit. In order to reduce the size of the system financial deficit and improve the financial sustainability of the system, a number of organisations have planned for significantly greater savings. Local places have worked in partnership to identify opportunities to improve services whilst reducing costs, and will continue to do so.

Placeholder for table showing system savings

Working at a system level has enabled progress to be made in system-wide programmes including unwarranted clinical variation, urgent & emergency care and clinically effective commissioning. Benchmarking information indicates that there may be significant opportunities in these areas. These system-wide efficiency plans will continue to be be developed through the operational planning process so that they can be throroughly tested and incorporated in organisations' plans in a more granular way. Alongside this, the system will be examining the return on investment of its increased spending on primary, community and mental health services – to ensure value for money and corresponding efficiencies elsewhere in the system.

The system makes full use of comparative information such as Model Hospital, Rightcare and GiRFT to proactively look for areas for improvement.

Specialised and Direct Commissioning

The system does not consider the provider envelopes set by the region to be based on

robust QIPP assumptions. We have identified the variance between locally modelled expenditure projections and the region's provider envelopes. This will be the starting point for working with the region on agreeing what reasonable efficiency assumptions would be. This dialogue will be ongoing beyond the window of the final submission.

Cash management

We will continue to actively manage cash whilst the system remains in deficit. Access to working capital will be agreed with NHSE/I on a timely basis to ensure that this does not impact on the delivery of services for patients.

The rest of this section sets out the enablers which will support the system on our route to financial sustainability.

5.2. Our system's financial framework

Sussex is on the ICS Accelerator Programme, and building a robust financial framework for the ICS and the ICPs will be an integral part of this work. There are some clear characteristics that are important in the development of effective ICSs/ICPs which include:

- A well constructed operating plan that aligns activity, finance and workforce
- A shared approach to investment
- System level financial governance arrangements
- Tools and systems that monitor progress
- Agreement on efficiencies to secure in-year and longer-term financial sustainability
- Aligned incentives and payment mechanisms.

To this end, the system's Finance Group is developing a financial framework underpinning the system's financial strategy. The intention of the financial framework is to guide system-wide planning towards financial sustainability, and to build collective responsibility for achieving this.

The framework first articulates system-wide shared planning principles – these incorporate the LTP's five financial sustainability tests. The principles also reinforce how system-wide financial planning should be aligned with agreed assumptions used in our local modelling system. These assumptions cover:

- Activity growth rates – based on locally agreed figures
- Cost inflation – based on nationally-aligned assumptions
- Tariff inflation and efficiency – based on nationally published figures.

Following this financial planning context, the framework sets out target and affordable spending by sector – including both health and social care expenditure, and incorporating funding guarantees for primary and community health. The projected *Do Nothing* risk by sector is then presented, which will be followed by a bridge of system-wide *Do Something* efficiencies to mitigate this deficit, together with the groups responsible for delivering these efficiencies. The purpose of setting out a bridge in this way is to drive delivery of and accountability for the efficiencies, thereby providing greater assurance on the route to system-wide financial sustainability outlined above. The resulting forecast Do Something spending will then be tested back against the target/affordable spending by sector to ensure overall alignment.

5.3. Developing system-wide financial assurance

The system has already achieved significant progress on developing financial assurance. Our Finance Group is regarded as an exemplar system-wide group in Sussex, developed on the principles of strong partnership working and transparent information sharing. The Group has a robust process for monitoring the system-wide financial outturn and can take collaborative action on contract alignment issues.

We have a robust modelling system in place which supports strategic planning by providing 5-year activity, finance and workforce forecasts for health organisations system-wide. This enables a good understanding of system financial drivers. Modelling assumptions have been developed collaboratively and are reviewed regularly. We are currently planning the next development phase of the modelling system, to support a direction of travel where modelled financial outputs more closely reflect and inform the reality of contracting agreements and internal funding flows.

Where contracting agreements or in-year trajectories diverge from those in the model, a clear audit trail is required to transparently account for this variance and system recovery actions put in place where required. This will provide the Finance Group with a more detailed level of oversight and enable it to take on a greater assurance role in collectively managing system resources.

As the Finance Group increasingly develops from a well-functioning group that oversees collaborative working and transparent information-sharing to one which takes on responsibility for system-wide financial assurance, we are learning from the working arrangements of Finance Groups in more mature ICSs.

5.4. Developing payment reform options

The system has already made good progress on this agenda, with most contracting arrangements already set up on an aligned incentive basis. We are currently examining options with the support of the national payment reform team – through a set of exploratory workshops with the Finance Group – for moving towards more sophisticated blended payment models. This will be coordinated in conjunction with the Accelerator Programme. Our system is committed to identifying and deploying innovative risk-sharing options through a process that collaboratively engages both providers and commissioners.

6. Putting prevention at the heart of our plan

6.1. Current state and challenges

Prevention is one of the central building blocks of our Sussex health and care strategic model and is, therefore, the responsibility of our whole system. A focus on prevention and on reducing health inequalities is central to the planning of all workstreams, and to our work around system reform and development towards becoming a maturing ICS. Our ambitions detailed in this strategy are not only the responsibility of the Prevention Board, but are dependent upon the work of the wider health service, councils, police, education, the voluntary sector, businesses, communities and individuals.

The Sussex Health and Care Partnership Prevention Board will work in collaboration with a number of Partnership-wide programmes in the implementation of primary prevention commitments, including those relating to cancer, and to long term conditions such as diabetes, CVD and mental health. Clinical programmes will lead strategic planning, delivery and monitoring of secondary prevention activities. However, pathways for secondary prevention and recovery pathways will be joined up with place-based delivery of local wellbeing services by Councils and other partners, to ensure a cohesive service and consistent outcomes for our population.

NHSE is responsible for commissioning public health services including NHS screening services, immunisation services, the Diabetes Prevention Programme, and child health information services. They are supported by, and work in close collaboration with, Public Health England (PHE), which delivers outcomes through regional Public Health Commissioning teams with their embedded Screening and Immunisation teams.

6.1.1. The wider determinants of health

We are committed to building a culture in which individuals, organisations and communities work together to identify and pool their capacity, skills, knowledge, assets and resources to improve health and wellbeing outcomes for all our residents.
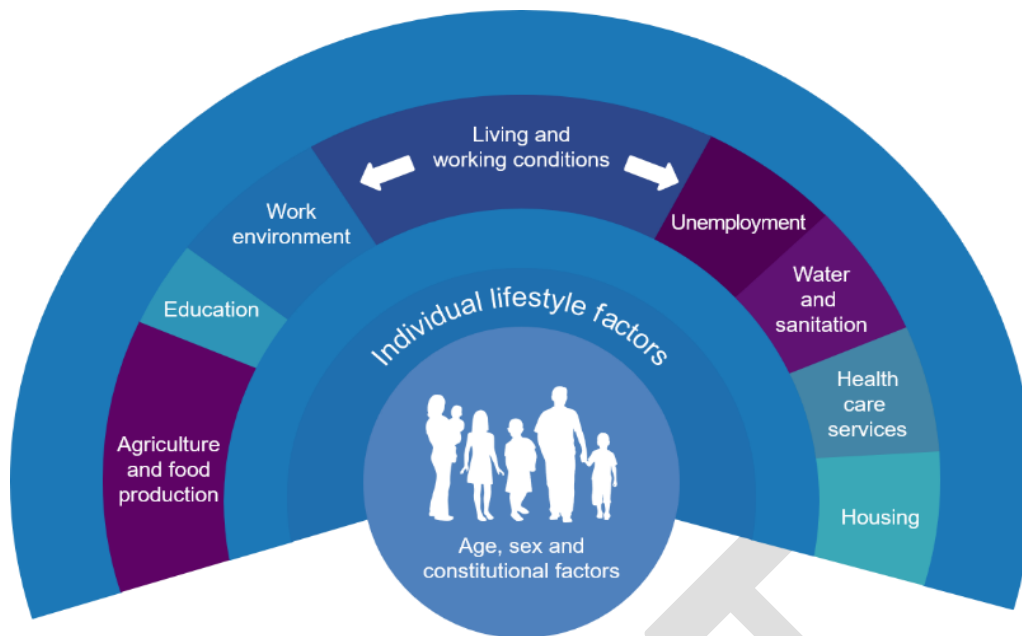
Figure 19: Individual lifestyle factors affecting health

This approach requires a shift from a demand management approach to a whole system approach to prevention which addresses "the causes of the causes" as identified in the Dahlgren and Whitehead model (1991). The "causes of the causes" cover a wide range of health determinants, from social determinants to those of the built environment, and these require concerted, sustained partnership working.

Social	Creating opportunities for people to participate in the life of the community: includes education and early childhood development, providing a sense of place, belonging and safety, information, inclusion, informal social support, health and community services, arts and culture, sport and leisure.	
Economic	Encouraging sustainable economic development and equitable access to resources includes: regeneration, job creation, training,	social protection, benefits, occupational health, safety and incentives.
Natural	Looking after natural surroundings and ecosystems: includes clean water, air, soil, natural heritage, land care, waste recycling, energy consumption and climate change adaptation.	
Built	Altering physical surroundings includes: urban layout, building design and renewal, housing quality, affordability and density,	parks and recreation facilities, roads, paths and transport, and the provision of other amenities, such as seating and toilets.

Figure 20: Health in All Our Policies (Local Government Association 2016)

6.1.2. **Our population and inequalities**

Our Joint Strategic Needs Assessments (JSNAs) highlight priorities for Sussex including:

Page 51 of 185

- Good mental health and wellbeing which underpins health outcomes
- Poor physical health which is linked to risk behaviours and influenced by the wider determinants of health
- Health inequalities resulting from social and income inequality
- Healthy futures which are built on stable employment and appropriate housing

These priorities for our population must be considered within the important context of the significant variations in socioeconomic status, health outcomes, environment and economic prosperity across Sussex. There remain considerable, and unacceptable, differences in service access, take-up, outcomes and life expectancy between areas across Sussex and within CCGs, which the Partnership is committed to addressing. One of the central tenets of our strategy is delivering high quality health and wellbeing for our most disadvantaged members of society through a Population Health Management Approach which may include targeting groups such as BAME communities or those with Learning Disabilities. We will ensure that we continue to monitor this variation for a range of measures including: cancer screening uptake, immunisation uptake, rates of smoking and alcohol misuse, and obesity levels, to assess the effectiveness of targeted and pilot interventions in areas of greatest need.

Life expectancy varies considerably across the area:[5]

- In Hastings & Rother, male disability-free life expectancy is over five years lower than in Horsham & Mid Sussex and High Weald, Lewes Havens (2010-2012)
- Hastings & Rother also has the lowest female disability-free life expectancy at 64.1 years, compared with Horsham & Mid Sussex at 69.4 years (2010-2012)
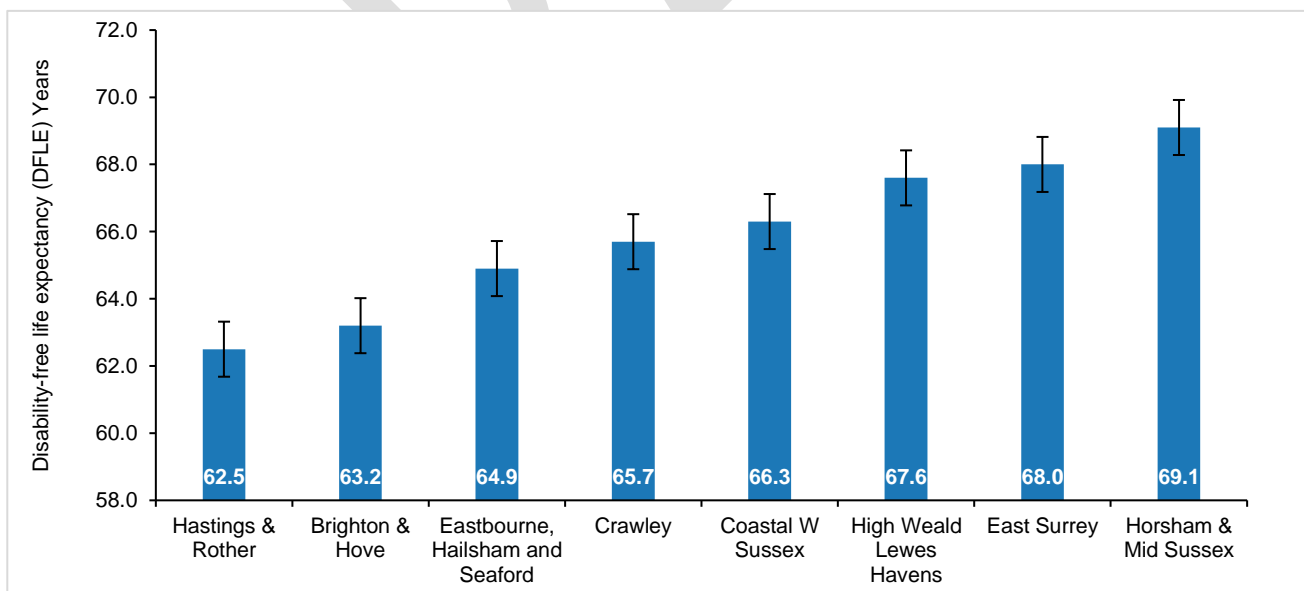
Figure 21: Disability-free Life Expectancy Men (2010-2012)

---

[5] Disability-free life expectancy 2010-2012, ONS
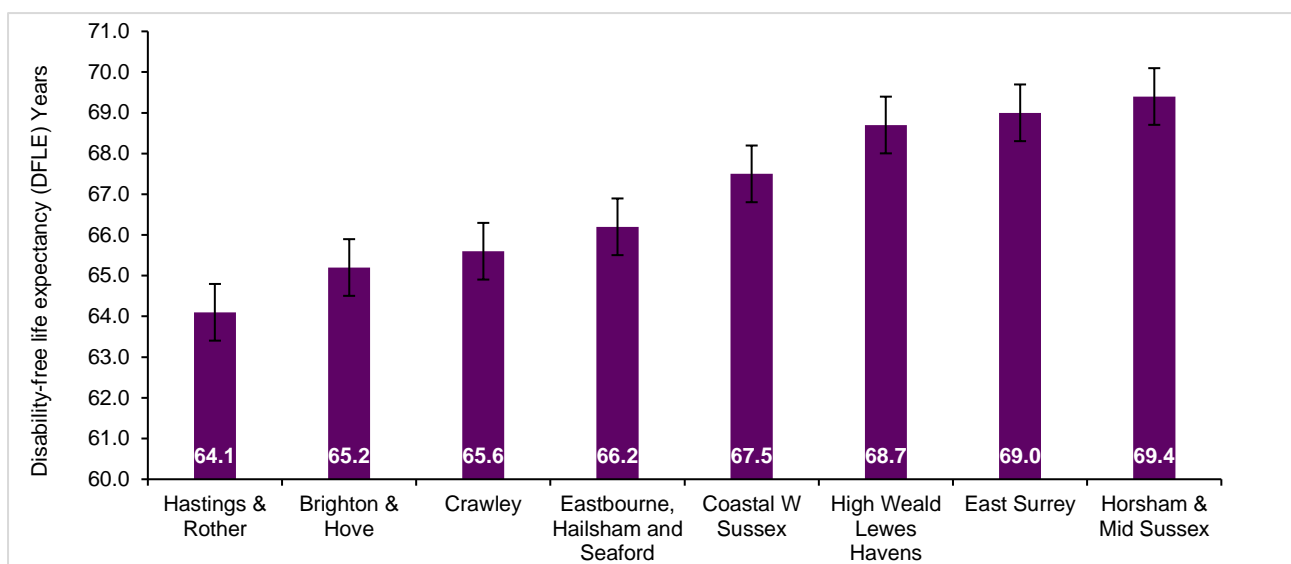
Figure 22: Disability-free Life Expectancy Women (2010-2012)

Deprivation is a significant driver of health inequalities and is notable along the coastal strip, particularly in Hastings which is the most deprived local authority in the South East. As a large Partnership, this understanding of our significant variation means that our three places and emerging Integrated Care Partnerships (ICPs) can specifically address inequalities by targeting interventions at areas of most need as indicated by our data on smoking, alcohol, obesity, deprivation and life expectancy.
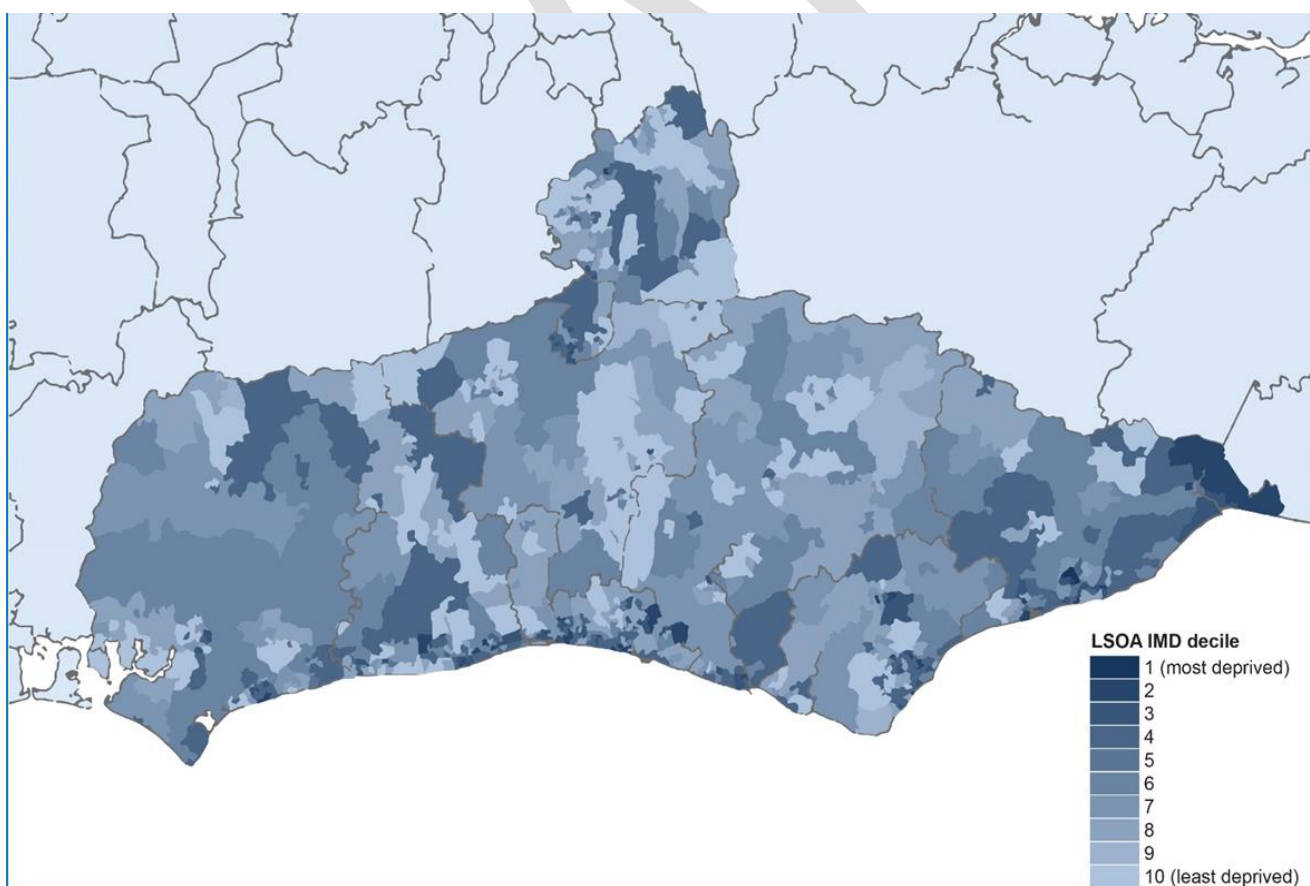
Figure 23: Deprivation based upon the Index of Deprivation 2015. The map is shaded according to the level of deprivation at neighbourhood level (Lower Super Output Areas). Areas shaded dark blue are some of the most deprived in England. DGLG Index of Deprivation 2015, Child Poverty rates HMRC as of 31 August 2015

Page 53 of 185

6.2. Key drivers

There are a number of contributory factors driving this variation including: smoking rates; poor diet; lack of physical activity; alcohol misuse; and mental health problems. Action to address these needs to recognise the extent to which they are influenced by social and

Modifiable risk factors (these can be reduced or controlled by intervention, and by doing so reduce the probability of disease)	Metabolic changes (biochemical processes involved in the body's normal functioning)	Long- term conditions
⟶		
• Tobacco use • Physical inactivity • Alcohol and drug misuse • Poor diet (increased fat and sodium, with low fruit and vegetable intake) • Mental wellbeing	• Raised blood pressure • Raised total cholesterol • Elevated glucose • Overweight and obesity	• Cardiovascular disease • COPD • Diabetes • Cancers • Dementia

economic inequality and the wider determinants of health.

Figure 24: Modifiable risk factors and long term conditions

To ensure that prevention is embedded throughout the day-to-day work of the Partnership, the Prevention Board will work in collaboration with a number of Partnership-wide programmes on the implementation of primary prevention commitments, such as reducing smoking and alcohol misuse. Clinical programmes will lead on secondary prevention with support from the Prevention Board and we will ensure that pathways are joined up through delivery of local wellbeing services at place level. Preventative activities to reduce CVD are covered by the unwarranted clinical variation programme, whilst Children and Young Peoples' mental health is addressed by the Sussex-wide Mental Health programme and at place level, and cancer screening by the Surrey and Sussex Cancer Alliance. Please see relevant sections of the plan and Appendix A for further detail.

PRIMARY Prevention

Acting to remove cause/reduce population level risk.

Working at a population/universal level.

Examples…

- Immunisation
- Getting people being active
- Working to improve economic development to tackle child poverty
- Helping parents, or prospective parents, to stop smoking so their children never consider starting smoking to be acceptable

Increasing physical activity in the population to reduce obesity

PREVENT

SECONDARY Prevention

Understanding risk groups/areas within the population.

Early identification and treatment of disease, with the aim to cure, slow progression or reduce impact

Examples…

- Screening programmes, NHS Health Checks
- Extra-curricular reading – programmes targeted at children on free school meals

Early identification of people with Type II diabetes, increasing screening of at risk groups

REDUCE

TERTIARY Prevention

Working with people once a problem has arisen to address the problem or reduce complications.

For some the ability to regain independence.

Examples…

- Ensuring best practice followed to manage a long term condition
- Gaining independence back after a fall

For people with diabetes to prevent and reduce complications of the disease, maintain health

DELAY

Wider determinants of health

Figure 25: Definitions of prevention adapted from NHS England Population Health Management Flatpack

6.2.1. A whole-systems integrated approach

Public health interventions have an important part to play in stemming the tide of long term conditions and increasing costs. Focusing on an integrated life course approach to prevention is required to tackle health inequalities, with the greatest benefit yielded from work in the early years of life. At the same time, Sussex is developing a whole-systems approach to prevention that will be delivered through oversight of the Sussex-wide Prevention Board, and responsibility for local health and wellbeing strategies at place level.

As well as individual service interventions, public health interventions to build stronger and more resilient communities and places to support prevention and self-management are vital across the NHS, local authorities, the voluntary sector, community groups, and wider stakeholders. This is why the Prevention Board includes membership from local authorities, Sussex-wide workstreams, Acute Trusts, Public Health England, NHSE and the AHSN and Clinical Senate.

When considering the role of the community, we also need to understand whether interventions are best placed at a Primary Care Network (PCN) level, place level (local authority) or system wide, Sussex level.

At the Sussex level, we are committed to achieving a smoke free Partnership within two

Page 55 of 185

years. We will also establish the role of NHS, Council and key partner organisations as anchor institutions, which is a term used to describe organisations whose long term sustainability is tied to the wellbeing of the populations they serve. Leading delivery of a healthy workplaces approach, and potentially an accreditation scheme for ICS organisations, is also a key responsibility of the Partnership. Across Sussex, we will develop a preventative ethos and culture across the health and social care workforce, by embedding an 'every contact counts' approach across the system.
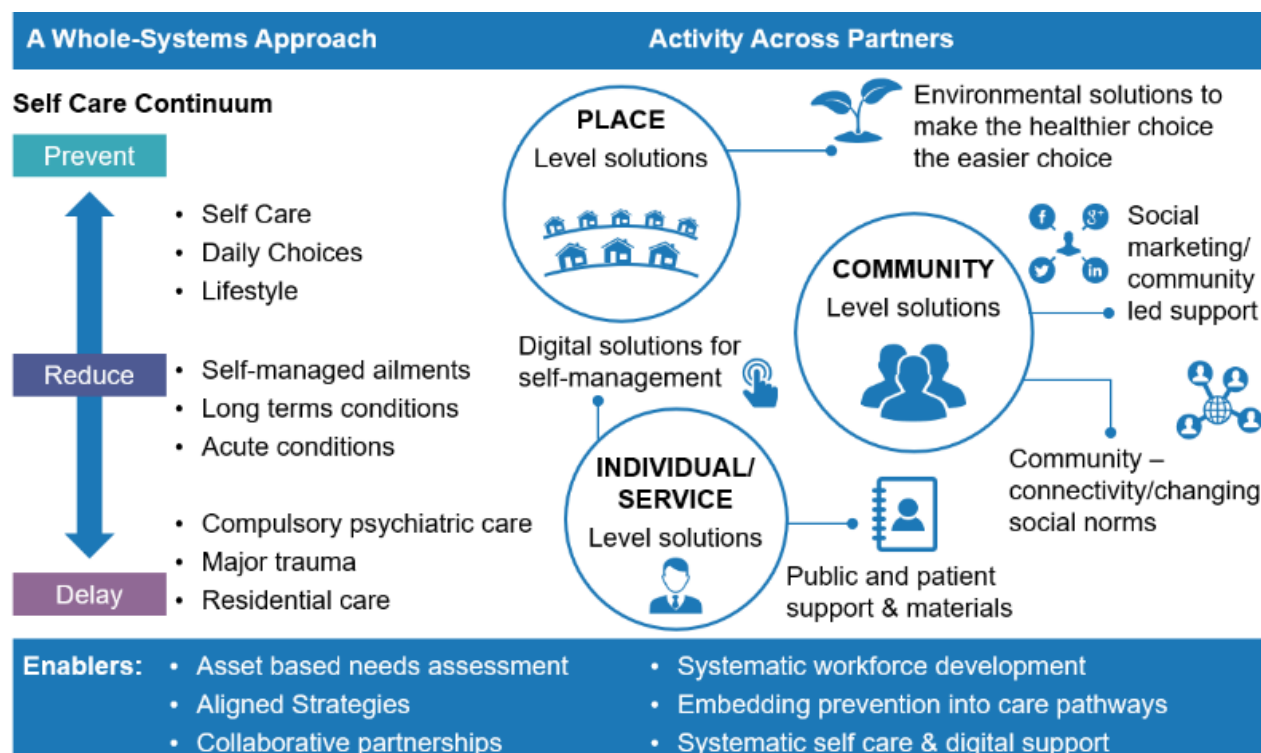
Figure 26: A whole systems approach to prevention

Our three places will support Sussex-wide prevention, but will have specific responsibility and to tailor and deliver:

- Early help services for young people and their families, including health visiting and school nursing
- Child and adolescent mental wellbeing and health services
- Adult social care support services
- Wellbeing programmes across each borough, including NHS Health Checks, as well as stop smoking services, increase physical activity, healthy diet and safe alcohol services
- Substance misuse prevention and treatment
- Sexual health prevention and treatment
- Approach to social prescribing services.

These actions will be supported by PCNs, which will contribute to our Sussex-wide commitment to prevention through:

- Identifying and targeting unimmunised children, young people and adults
- Identifying and targeting unscreened children and adults

Page 56 of 185

- Making every contact count regarding smoking, alcohol, physical activity, healthy diet and mental wellbeing and referring people into health promotion and support services
- Embedding social prescribing across primary care services to support vulnerable adults and their families.

6.2.2. Five year vision

We are taking the opportunity of the Long Term Plan both to respond to key targets and to go further in galvanising the system around the ambitions to take a broad approach to prevention across Sussex and to integrate prevention activities within specific clinical workstreams. For more information on a number of preventative activities, please see sections 7.2 on Cancer, 7.4.5 on major health conditions, 7.3 on Mental Health and 7.4.4 on Unwarranted Clinical Variation, as well as Appendices B-C for place-based contributions to programmes such as Ageing Well.

The Prevention Board has six key objectives to support our population at each stage of life, including:

- Supporting a good start in life, including delivering a whole systems approach to healthy weight, and promoting emotional wellbeing and good mental health in children and families
- Improving the health and wellbeing of working people, for example, through the development of workplace programmes across Sussex
- Preventing the development of long term conditions (LTCs) through primary prevention programmes focused on the major causes of ill health.
- Improving health outcomes for people with LTCs including cancer, cardiovascular disease, diabetes and mental health conditions, through a staged approach of early detection, support for self-care and robust clinical management
- Supporting our population to age well by promoting both physical health, for example through falls reduction programmes, and mental health, through community-based programmes to alleviate isolation
- Recognising that a good death is as important as a good birth, and therefore supporting people to die in their preferred place of death, supported by the highest quality end of life care
- Taking an asset-based approach to supporting wellbeing, which focuses on 'what matters to people' rather than 'what's the matter with people'.[6] We will do this by strengthening social networks and communities, and maximising the impact of social prescribing to empower citizens to make healthier choices.

6.3. Key priorities to delivery five-year vision

The key priority for 2019/20 is to establish the Prevention Board, which is currently in a nascent state, and to develop a comprehensive strategy that links all our ambitions and workstreams together coherently. We will embed the expectation that all workstreams should

---

[6] Please see 'Our Population Health Check, A Clinically-led Diagnosis of What Needs to Change' for further details.

be prioritising prevention, and sign off this Partnership-wide improvement programme involving all partners by 2020/21.

The Sussex Partnership is committed to prioritising prevention, which is demonstrated by the approach that prevention is not just the responsibility of the Prevention Board, but of all workstreams. This committment is demonstrated by the allocation of 30% of 'Other' Fair Shares funding from the Long Term Plan to preventative activities from 2021/22 – 2022/23, and 20% in 2023/24. This is a higher percentage than recommended by NHSE and will be used to support our current priorities and those determined through further strategic planning over the following year. Please see the Strategic Planning Tool for further detail on the allocation of Fair Shares funding by provider.

For 2020/21 our initial four priorities at Sussex level are:
- To achieve a smoke free ICS by 2021 by scaling up Stop Smoking Services and Smokefree NHS Trusts
- To establish the role of the NHS, Councils and key partner organisations as anchor institutions to influence the wider determinants of health
- To maximise the workforce contribution to prevention by facilitating a shift in culture so that prevention is everyone's responsibility, and to upskill our workforce for this
- To develop and roll out a Healthy Workplace Programme to include support for active travel, healthy eating and physical exercise. This may potentially include a workplace accreditation scheme for ICS organisations.

Priority prevention areas are detailed below, including specific actions, funding, outcome metrics and targets. For further information, please see Appendices A, B, C and D for some five year phasing and place-based commitments supporting Sussex-wide work.

6.3.1. Smoking

Given that Crawley, Brighton & Hove, and Hastings & Rother have a smoking prevalence above the national average, these are the areas where we would target our smoking cessation programme for inpatients. We would pilot our smoking cessation programmes for inpatients from 2020/21, potentially starting with maternity and mental health patients, working in partnership with the Local Maternity System (LMS) and Mental Health Programme, before subsequent full roll-out.

CCG	Smoking prevalence % (GP patient survey 2018)
England	14.6
Sussex	13.9
Crawley	**16.8**
Brighton and Hove	**16.5**
Hastings and Rother	**16.4**
Eastbourne, Hailsham and Seaford	13.1
Coastal West Sussex	13.0
High Wield Lewes and Haven	12.0
Horsham and Mid Sussex	11.0

Figure 27: Smoking prevalence by CCG

Page 58 of 185

This would be based upon the Ottowa model, and the general smoking cessation programme has been modelled at between £274,805 and £347,395 for total acute costs excluding ongoing NRT, based upon services offered to all patients and an expected uptake of 27% based upon previous trials.[7] Dedicated programme managers will oversee the planning and delivery of a smoke free ICS by 2021. We are committed to using the Fair Shares funding allocated to prevention to support the smoking cessation for inpatients and pathways into community services. For more information, please see Appendix A.

Priority areas

- Target short and long term benefit at PCN, ICP and Partnership level, using resources effectively and responding to local health risk and need.
- Focus on the smoking cessation model, targeting expectant mothers and all those admitted to hospital who smoke, based on the Ottowa model. See Appendix A for more detail.
- Structured approach to very brief advice (VBA) that fits with Population Health Management. Continued support across the system based on a proven model (incl PH48). Review options for more lung CT scanners .
- Evidenced-based approach to e-cigarettes included in all policies.

Metrics and targets

- All NHS and Council sites to be smoke free by 2021.
- Inpatient smoking cessation programmes to be piloted for maternity and mental health patients from 2020/21 with wider roll-out following evaluation.
- Percentage of inpatients offered smoking cessation.
- Percentage uptake of offer (based upon *Hiding in Plain Sight study* from the British Thoracic Society which assumes 27% acceptance*)*
- Smoking rates by CCG.

(Metrics still under development)

Figure 28: Smoking priority areas

[7] See 'Hiding in Plain Sight', British Thoracic Society Audit

6.3.2. Alcohol

We know that alcohol misuse is significant in Hastings & Rother, Brighton & Hove and along the coastal strip in West Sussex, particularly for our younger populations. Therefore, we believe that there is a strong case for investment given the level of need and the cost-effectiveness of interventions around alcohol care teams.

CCG	Admissions episodes for alcohol-specific conditions – Under 18s (crude rate per 100,000 2015/16-2017/18)
England	32.8
Sussex and East Surrey	37.8
Hastings and Rother	**54.4**
Brighton and Hove	**51.9**
Coastal West Sussex	**38.0**
High Weald Lewes Havens	**34.8**
East Surrey	**33.5**
Eastbourne, Hailsham and Seaford	30.9
Horsham and Mid Sussex	28.8
Crawley	24.9

Figure 29: Alcohol related admissions by CCG

As an ICS, we recognise that, irrespective of national ranking, alcohol misuse not only affects the health and wellbeing of large numbers of residents but also places considerable pressure on health and social care services. We would target alcohol care teams at BSUH, Conquest Hospital in Hastings and Worthing Hospital in Coastal West Sussex (CWS) with service models tailored to local needs, which would likely be 7-day services at an estimated cost per setting of £165,000-£180,000.

Page 60 of 185

Priority areas	Metrics and targets
• Target short and long term benefit at PCN, ICP and Partnership level, using resources effectively and responding to local health risk and need. • Focus on the smoking cessation model, targeting expectant mothers and all those admitted to hospital who smoke, based on the Ottowa model. See Appendix A for more detail. • Structured approach to very brief advice (VBA) that fits with Population Health Management. Continued support across the system based on a proven model (incl PH48). Review options for more lung CT scanners . • Evidenced-based approach to e-cigarettes included in all policies.	• All NHS and Council sites to be smoke free by 2021. • Inpatient smoking cessation programmes to be piloted for maternity and mental health patients from 2020/21 with wider roll-out following evaluation. • Percentage of inpatients offered smoking cessation. • Percentage uptake of offer (based upon *Hiding in Plain Sight study* from the British Thoracic Society which assumes 27% acceptance) • Smoking rates by CCG. (Metrics still under development)

Figure 30: Alcohol priorities

6.3.3. *Obesity*

Diet, nutrition and physical activity are key priority areas for primary prevention to reduce the prevalence of long term conditions such as cancer, cardiovascular disease and diabetes within our population.

CCG	Obesity % (QOF prevalence (18+) 2017/18)
England	9.8
Sussex and East Surrey	7.8
Crawley	**10.8**
Hastings and Rother	**10.0**
Coastal West Sussex	8.8
Eastbourne, Hailsham and Seaford	8.1
High Weald Lewes Havens	6.7
Horsham and Mid Sussex	6.6
East Surrey	6.3
Brighton and Hove	5.5

Figure 31: Obesity prevalence by CCG

We are undergoing an options appraisal for a Sussex-wide Tier 3 service to ensure equity of access to weight management services, and further measures to manage adult and childhood obesity will be considered as part of our detailed strategy development during 2019/20 and 2020/21.
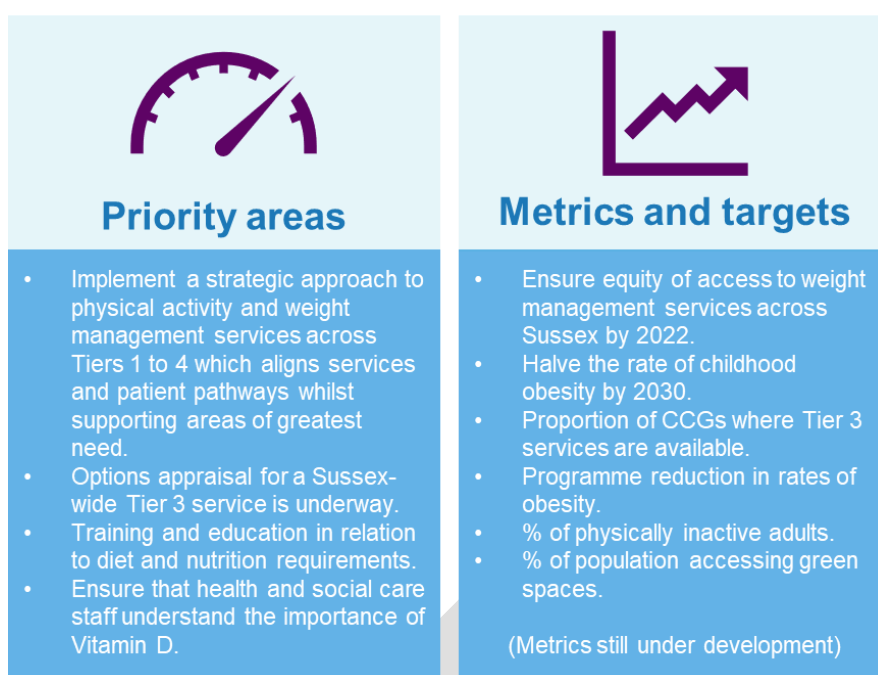
Page 61 of 185

Figure 32: Obesity priorities

6.3.4. Immunisations

Although our immunisation rate of 92.3% across Sussex is above the English average, only one of our CCGs currently reaches the 95% target required for effective herd immunity. The causes are multifaceted and include misinformation, access, and a lack of awareness about disease prevention. This places our population at risk of preventable diseases and is a local priority for Sussex given a number of recent measles outbreaks coinciding with the World Health Organisation removing the UK's measles elimination status.

CCG	MMR vaccination for one dose (2 years)
England	91.3
Sussex and East Surrey	92.3
Horsham and Mid Sussex	95.9
Crawley	**94.7**
Coastal West Sussex	**94.1**
Eastbourne, Hailsham and Seaford	**94.1**
Brighton and Hove	**91.3**
High Weald Lewes Havens	**91.3**
Hastings and Rother	**90.3**
East Surrey	**84.8**

Figure 33: MMR vaccination rates by CCG

To achieve our aim of reaching a 95% immunisation rate for the second MMR vaccination, we will support all PCNs to identify and put more support in place to reach unvaccinated children. We will promote joined-up working between the Vaccinations and Immunisations team, commissioners and the Prevention Board. Working with the Screening and Immunisations team, we will address health inequalities in screening and vaccination

Page 62 of 185

programmes through the identification of variation and under-represented groups, through Health Equity Audits and specific targeted interventions for key groups and for geographical areas where there are identified inequalities, such as in Hastings & Rother.
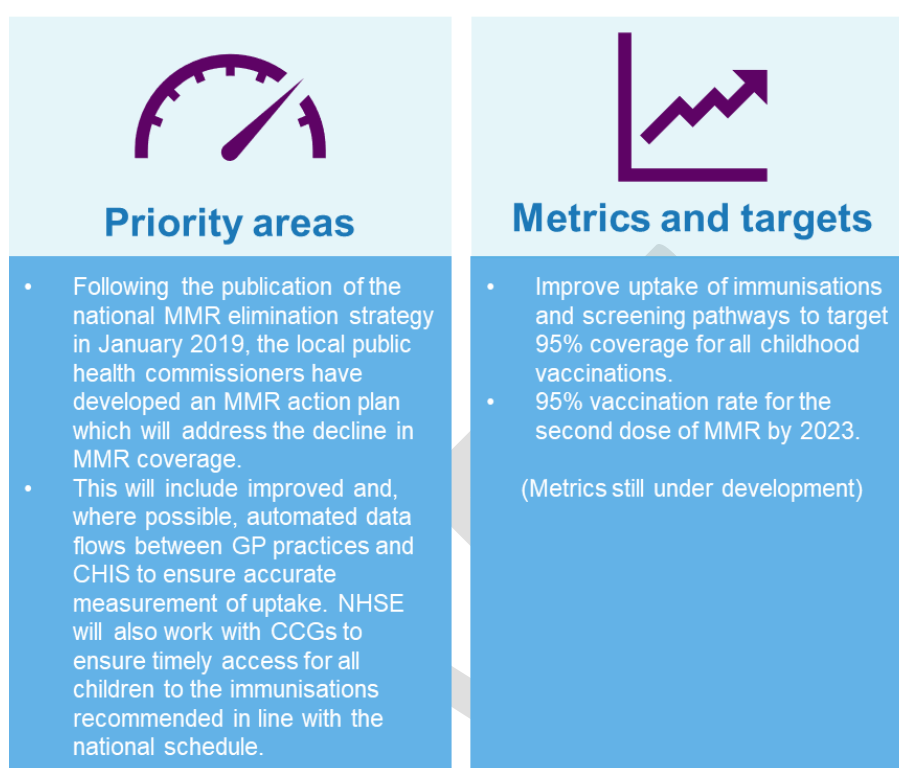

Priority areas

- Following the publication of the national MMR elimination strategy in January 2019, the local public health commissioners have developed an MMR action plan which will address the decline in MMR coverage.
- This will include improved and, where possible, automated data flows between GP practices and CHIS to ensure accurate measurement of uptake. NHSE will also work with CCGs to ensure timely access for all children to the immunisations recommended in line with the national schedule.

Metrics and targets

- Improve uptake of immunisations and screening pathways to target 95% coverage for all childhood vaccinations.
- 95% vaccination rate for the second dose of MMR by 2023.

(Metrics still under development)

Figure 34: Immunisation priorities

6.3.5. Further programmes

Additional areas of focus for the Prevention Board are detailed below, including primary prevention as detailed in our strategic delivery plan under section 7.2 on cancer and 7.3 on mental health. These areas will be further considered during the development of our comprehensive prevention strategy over the following year.

Health inequalities	• Identify gaps and develop targeted plans taking a proportionate universalism approach at place level in relation to the largest local drivers of inequalities. • Align priorities and plans with the three place based Health and Wellbeing Board strategies. See Appendices B, C and D for more information on place-based prevention priorities. • Maximise our role in sustainably addressing the wider determinants of health – as an employer, commissioner and contractor. • Increase public awareness by improving approaches. For example, 'Making Every Contact Count' and health checks. • Work with PHC who will carry out Health Equity Audits to address inequalities in screening and vaccination programmes with specific targeted intervention for key groups and geographical areas.
Cancer screening	• Supporting the Sussex Cancer Board and Surrey and Sussex Alliance in development and implementation of their 5 year strategy around screening, including through Local Commissioned Services (LCSs) at place level. • Universally delivering new screening tests, rapid diagnostic services and improving uptake amongst populations with the lowest rates of uptake. For bowel screening, this is Crawley CCG (52.5%) and for breast and cervical this is Brighton & Hove (65.9% and 68.2% respectively).
Children and young people	• Systematic NHS approach to children's prevention and treatment pathways, including adopting family-based approaches across the NHS. • Childhood obesity programmes at place level, including sugar reduction and physical activity in schools. • Child and maternal health, including safe places to live and grow up, in collaboration with the Local Maternity System. • Strengthen action to address emotional and mental wellbeing of children and young people through close collaboration with the well-developed Sussex Mental Health Programme.
Healthy and sustainable places and communities	• Implement the NHS action plan on air quality through the Sussex Air Quality Partnership (Sussex-air) which is well established in supporting Sussex authorities with their duties under the Environment Act 1995. This work will largely be delivered at place-level through local air quality strategies, such as the West Sussex 'Breathing Better' strategy developed in May 2018. • System wide and place level approach to enablers of healthy communities, including housing, green spaces and arts.
Mental health	• Mental health education in schools to promote resilience. In 2019/20, there will be 7 Mental Health Support Teams in Schools in Sussex and we will support the Sussex Mental Health programme to cover between a quarter and a fifth of Sussex by 2023/24. • The Mental Health Programme is developing a suicide reduction programme, including self-harm, for full implementation from 2021/22. Suicide bereavement support services will also be available across Sussex by 2023/24. See Appendix A for more detail. • Develop a joint mental health / prevention strategy across the Sussex Partnership in 2020/21 ensuring this strategy integrates with place-based commissioning and provisioning around wider local services for substance misuse, housing and homelessness.

Antimicrobial resistance	• The commissioning quality team has developed a two year clinical strategy for infection prevention. This will take a system-wide approach to reducing health care associated infections (HCAIs) through close provider and commissioner collaboration aiming to:
	   • reduce key alert organism gram negative bacteraemias by 50% by 2024
	   • reduce inappropriate antimicrobial usage
	   • adopt national campaigns such as Target
	   • comply with the National Quality premium/CQUIN antimicrobial targets.

6.4. **Governance**

The Sussex Prevention Board will take a Population Health Management approach to improve healthy life expectancy and reduce dependency on health and care services through a radical upgrade in prevention, early intervention and self-care. The Board will seek to take a common approach where working together as a system would add value to improving prevention and reducing health inequalities, for example, with regards to smoking, alcohol misuse and weight management services. However, other action to coordinate prevention will still take be undertaken at place level, such as delivering local Health and Wellbeing Strategies. The Board includes membership from other clinical workstreams, such as the Mental Health Programme, CVD and MSK programmes, and the STP Cancer Board, with clinical leadership to jointly chair the board with the Directors of Public Health. The role of the Prevention Board will be to:

- Coordinate and maintain oversight of the Sussex prevention plan.
- Agree the programme plan and priorities of the workstream programmes.
- Promote strong and effective co-production in the development and implementation of the programme, ensuring inclusion of the views of service users and their families and carers.
- Monitor outcomes and trajectories of reporting programmes and support them to overcome challenges escalated.
- Advise and identify innovative, cost effective, evidence based and affordable solutions for achieving progress. Identify a range of existing and potential levers for securing investment.
- Bring together the input of local NHS organisations, Public Health England (PHE), NHSE and Local Government Public Health to ensure maximum efficacy around prevention.
- Embed prevention priorities in individual organisations, local delivery systems, and across other Sussex-wide workstreams.
- Link to Health and Wellbeing Boards across the three Sussex places.

6.5. Interdependencies

Core interdependencies are shown in the table below. The Prevention Board will work closely with these workstreams in developing and embedding prevention throughout Sussex.

Workforce, people and culture	• There are existing workforce challenges in breast radiology and radiography, endoscopy, histopathology and colposcopy which all need to be addressed through workforce planning. • Universal commitment to, and understanding of, the opportunities and benefits in relation to prevention. • Workplace health and wellbeing – systematic approach across all ICS organisations. • Cultural change around embedding the relevance of prevention to all clinical workstreams. • Embed 'Making Every Contact Count' in job descriptions across the health system. • Maximise the role of the NHS in addressing the wider determinants of health.
Digitalisation IMT and analytics	• Support people to use their personal health data for prevention. • Population health management to inform the timing and nature of prevention interventions, supported by integrated health and care records. • Consistent messaging and approach on prevention delivered through Apps. • Improved data exchange between primary care and A&E. • Capability to track interventions in relation to prevention. • Data analytics to measure and compare outcomes.
System financial management	• Transfer resources towards prevention and away from treatment on an incremental basis which aligns with the shift of resources from acute to primary and community care. • Defining financial model for prevention to align with QIPP.
Cancer Alliance and LMS	• Improve breast, bowel and cervical screening uptake. • Improve childhood and immunisations screening to meet minimum standards consistently across Sussex.
CVD, Falls, MSK and Mental Health	• Primary prevention programmes focused upon these major causes of ill health. • Empower citizens to remain independent in their own homes and to be supported by their communities in doing so.
Sexual Health	• Maintain and enhance an integrated approach to sexual health pathways in line with the aspirations set out in the LTP.

7. Our transformation priorities

7.1. Developing a new service model centred around place-based joined-up care

As set out in the Sussex Health and Care strategic model in section 3.2.7, places will provide joined-up primary, community and local hospital services in the local area such that services can be designed around individuals and allow for seamless movement between primary and community health, social care, and local hospital services in a timely and efficient manner.

Responsibility has been devolved to the places for service transformations and delivery in the following areas:

- Transforming out of hospital and community-based care
- Reducing pressures on urgent and emergency care
- Giving people more control over their own health and more personalised care
- Reducing waits for planned care
- Effecting digital transformation of primary care and outpatients.

This chapter sets out the common principles behind place-based plans in these areas – full detail of the place-based plans, including but not limited to more detailed implementation plans for the areas above, are in Appendices B, C and D. Appendix A contains the line by line responses to the LTP commitments, and place-based detail can be found in tabs "Brighton & Hove", "East Sussex" and "West Sussex".

The full place-based plans have been written by the "system" of partners in each of the places, comprised of acute, community, and mental health providers, commissioners and local authorities. Each of the place-based plans is locally owned and reflects the health and care needs of the local population, with specific local priorities and implementation plans to reflect local need. There has been a significant degree of engagement across the "system" of partners in each place in the development of these plans, which has not consistently happened before. Plans also address the development needs for the governance in each place, which varies dependent on maturity of relationships.

Places also play a crucial role in the implementation and delivery of Sussex-wide strategies, such as prevention, mental health and cancer. The role of places in these areas, where strategy is set Sussex-wide, is to implement and deliver the strategy where the appropriate level of delivery is "place" (as opposed to complex or specialised services delivered Sussex-wide), and to localise specific areas of planning where local need dictates a different approach for each place. Place-based plans set out the implementation and localisation of Sussex-wide planning, with the degree of detail and ambition reflective of the local prioritisation for each place.

Places have also taken the lead on the development and articulation of planning around services for Children and Young People (see section 6.5.2) and Respiratory (see section 6.5.5).

7.1.1. Transformed out of hospital and community-based care

Faced with an ageing population who have multiple long term conditions, we intend to provide an integrated model of care that focuses on keeping our population out of hospital when an acute environment is not the most appropriate location for care, while looking to the community as a key location where more of our care will be delivered.

Integration is a core component of transformed community-based care. Places are supporting the development of their PCNs (see section 4.3) and are developing the model and ways of working between primary and community care around PCNs. Places have worked closely with local government through the Better Care Fund and have seen good whole system performance against the Better Care Fund targets. We will continue to use this to introduce services changes in line with the commitments from the Long Term Plan, such as the Carers' Hub in Brighton & Hove.

As part of our commitment to our ageing population and our view to integrate services and move care into the community, we intend to work across acute providers, community and social care to reduce the volume of DTOCs (delayed transfers of care) in our system, ensuring that our population receive the right care in the right place at the right time.

We are addressing four key priorities within community care, as laid out in the Long Term Plan: improved crisis response within two hours and reablement care within two days; anticipatory care jointly with primary care; supporting primary care to develop Enhanced Health in Care Homes and developing a carer-friendly NHS. Places have been asked to develop their own plans within these areas which support our Sussex-wide strategy whilst being responsive to local needs. Full timelines for transformation of out of hospital and community-based care can be found for each place in the Appendices.

Priorities within community care are also all strongly linked to the Sussex-wide unwarranted clinical variation programme focusing specifically upon CVD, MSK and falls and fractures. See section 7.4.4**Error! Reference source not found.** for further detail.

Improved crisis response and reablement

There is some variation across Sussex in delivering crisis response within two hours based on historic commissioning and system arrangements. However, some areas are delivering this already and we will build on this strong foundation to ensure all services can meet this requirement consistently across Sussex.

Ensuring areas have effective and efficient single points of access to crisis response and reablement is also vital to their success. Whilst there is some variability in infrastructure across Sussex to provide this, many areas have or are already moving to single points of access which will underpin multidisciplinary crisis response.

The system-wide Step-Up Step-Down Programme focuses on the clinical, rehabilitation, and reablement models required to support care closer to home by aligning and clarifying roles for provision of a more integrated model for community crisis response and reablement. Alongside this, we are focusing on methods to improve discharges, through the roll-out of Home First pathways and Integrated Discharge Teams, for example. In addition, crisis response teams will also play a role in admission avoidance and therefore contribute to reduced pressures on emergency services, as set out in section 7.

The Community Services Dataset is a fundamental building block in unlocking the full

potential of clinical and digital transformation, by allowing community service providers and commissioners to view local and national information from community services. Places have local plans to improve local system usage.

For full detail of implementation of crisis response and reablement in each place, please see the Appendices.

Anticipatory care

Anticipatory care is a key deliverable for Primary Care Networks. In bringing General Practice and community services together around populations, we can build on existing Community of Practice models across Sussex and support people to make informed decisions about their own care as well as receive timely support from local services.

We have learned that where this approach is most effective it is built on evidence-based risk stratification. We will be enabling places to secure the right systems to underpin this through commissioning and system-wide digital solutions.

Patients supported through anticipatory care will each have a clear plan built around their needs which aims to avoid unnecessary admissions and deterioration, not only for the most high-risk patients but also for those at risk of future ill health. Anticipatory care plans will include: named point of contact, normal observations, and contingencies to ensure that patients/professionals know what to do pre and during crisis to manage their conditions and situations. These plans will be shared across all services to ensure that however and wherever a patient presents the plan will be enacted. Patients approaching end of life will also be supported through advance care planning to make joint decisions relating to preferred place of care and death to improve experience and reduce invasive interventions which focus on prolonging life rather than quality, comfort and dignity.

For full detail of implementation of anticipatory care in each place, please see the Appendices.

Enhanced Health in Care Homes

There are a number of Locally Commissioned Services for Enhanced Health in Care Homes already in place across Sussex which will support our ambition to enable our population to age well. This programme will utilise collective General Practice and community services through Primary Care Networks and aims to reduce acute hospital admissions by enabling better early identification and forward care planning. The places are working with their partners to further roll-out these services across nursing and residential care, including by providing training programmes for care homes. We will ensure that there is place-wide and consistent coverage of these services, but also that support to develop these services is targeted at areas of most need.

Further support is being provided to care homes, such as assistance to register for NHS.net email addresses and complete the Data Security and Protection Toolkit to enable care homes to register for a shared mailbox.

For full detail of implementation of Enhanced Health in Care Homes in each place, please see the Appendices.

A carer-friendly NHS

To deliver integrated community health and social care, we need to support all members of our population and the better identification of carers is key to this commitment. We need to provide better information and support to carers through a variety of methods including single points of access to dedicated carers' services, digitally-enabled solutions such as the Jointly app funded by Brighton and Hove City Council and the CCG, which enables carers to store and share all the important information about someone they care for with professionals and across organisations, and health support such as the Carers Health Team in West Sussex. Our places will also consider how commissioning of carer identification and support can be extended into the primary care setting to be delivered in collaboration with PCNs as part of the implementation of Universal Personalised Care.

For full detail of the implementation of a carer-friendly NHS in each place, please see the Appendices.

7.1.2. Reducing pressures on urgent and emergency care services

Reducing pressures on urgent and emergency care services

Urgent and Emergency Care (UEC) should be focused on unplanned incidents and, in the case of emergency care, is the highest escalation point of patient care. However, all too frequently our A&Es are seen as the default alternative for gaps in the provision of or access to other services, resulting in rising demand, departmental overcrowding and long delays for patients.

Over the next five years, we will continue to develop our strategic networked model for urgent care that delivers fully integrated services, is aligned across the Sussex footprint, and meets the needs of the whole patient population. We will focus on pre-hospital and Same Day Emergency Care (SDEC) interventions to target a reduction in A&E referrals and admissions, and ensure patients are seen in the most appropriate setting.

Current state and challenges

Our community, acute and primary care services are fragmented and can be very different across commissioning group boundaries. This is not helpful for patients and makes services unsustainable both financially and for our work force.

In line with the national trend, our emergency care system is under real pressure. Attendances at our A&E Departments continue to rise with a 13% overall increase in demand on our acute trusts over the last year. Our ambulance services are facing significant handover delays at our A&Es, increasing cycle times and 999 response times for our patients.

For example, between 24th Dec 2018 and 2nd Jan 2019, SECAmb lost in excess of 1,800 operational ambulance hours to turnaround delays greater than 30 minutes. This was a 43% decrease over the same period of the previous year; however, this is still equivalent to losing eight ambulances on duty every day of this 10 day period.

All of our acute trusts have service improvement plans in place with trajectories established towards achieving the 4-hour target; however, increasing demand across all areas in the system means that this remains a challenge. Whilst individual trusts occasionally meet the 95% 4-hour A&E waiting time standard, as a whole the Sussex Health and Care Partnership has not met the standard since it was formed in late 2015. The move of focus to clinical urgency that is expected from the Clinical Review is welcome, both from a clinical safety perspective and as an enabler to better influence patient behaviours towards alternative, more appropriate care pathways. We look forward to working with the regulator to baseline current performance and agree consistent interventions and enablers to achieve the new targets, in line with the commitment that systems will be supported to achieve the new access standards set by the Clinical Review.

Pre-hospital urgent care

Our goal is to ensure patients receive the most appropriate care in the most appropriate setting. For many patients this is not A&E, and improved access to effective pre-hospital care, including primary care services, will reduce emergency attendance and admissions. Our key priorities for pre-hospital care are shown below.

NHS111-CAS	• Increase ability to directly book appointment with an appropriate Health and Care Professional (incl. GPs, community services and UTCs) • Improve outcomes from of NHS111-CAS to increase 'consult and complete' capabilities, reduce levels of ambulance and A&E referrals and increase self-care dispositions • Undertake public engagement to improve awareness of alternatives available for the provision of care and increase use of NHS111-CAS
A&E Attendances	• Deliver and maintain Carter review recommendations in ambulance services to meet Ambulance Response Programme (ARP) targets incl. avoidable ambulance conveyances • Develop the CAS as the SPoA for patients, carers and HCPs accessing integrated care services, support admissions avoidance and facilitate hospital discharges • Increase the volume; quality and accessibility of anticipatory care plans to reduce unnecessary conveyances and admissions to hospital; • Develop shared workforce models (e.g. rotational paramedics) working across GP practices; EOC and on scene and extending to other appropriate urgent care services e.g. UTCs, CAS and Home Visiting to improve outcomes at the point of contact. • Extend care pathways in the community and increase capacity in out of hospital and responsive services to keep people at or closer to home;
Integrated Services	• Implement the Urgent Treatment Centre model so that all localities have a standardised offer for out-of-hospital urgent care • Work in partnership with Primary Care Networks to establish consistent place based integrated models of care • Transition to and imbed new ways of working as digital solutions, NHS111-CAS, PCNs start to impact patient demand and flow • Aligning and increasing admissions avoidance and discharge enablers (including patient transportation) to improve hospital flow and reduce admissions and lengths of stay. • Focus on and improve levels of Long Length of Stay (LLoS) patients and Delayed Transfers of Care (DTOCs) working collaboratively with local authorities and out of hospital services.

Same Day Emergency Care (SDEC)

Our Population Health Check estimated that over a quarter of all attendances at A&E could have been treated at another suitable location. Across our footprint we have significant variation in patterns of hospital use and admission, with Coastal West Sussex CCG (CWS) and areas of East Sussex showing levels of hospitalisation almost four times as high as in other areas of the Partnership.

Our focus will be to increase the provision and capacity of SDEC services, aiming to deliver consistent services for 12 hours per day, 7 days per week by September 2019 and 30% of non-elective admissions via SDEC by March 2020.

Particular challenges exist with SDEC services being used as A&E overflow areas to reduce overcrowding. We are working with providers to support operational improvements in flow and better manage demand to enable the consistent delivery of these services, with particular focus on reducing conveyances and ED referrals by ensuring patients are directed to the right service to meet their need.

In support of effective SDEC services, we are working with clinicians across the footprint to develop standardised care pathways that extend into the community and scale admissions avoidance initiatives. For example, developing a Health Care Professional (HCP) Single Point of Access (SPoA) solution will provide a rapid, easy-to-access resource to support clinicians in identifying alternative and more appropriate pathways of patient care.

Reducing avoidable conveyances

There are a number of different workstreams and priorities that will contribute directly to our ability to reduce ambulance conveyances. These include:

- Developing SDEC services that support direct referrals
- Improving crisis response services in the community to enable more patients to be treated at home
- Developing DoS and Service Finder solutions to present crews with appropriate alternatives
- Increasing the volume, quality and accessibility of anticipatory care plans
- Developing an ambulance crew workforce and operating model to ensure crews can access experienced crew members to validate conveyance decisions.

Governance and performance

To support continued delivery against our priorities, performance against improvement trajectories will be monitored through Local A&E Delivery Boards and overseen by the SHCP Executive. Issues and risks that need to be considered at scale will be escalated through the UEC Steering Group.

A single strategic commissioning function will be established to coordinate commissioning activities, applying a consistent set of principles and common ways of working across Sussex. Whilst implementation, relevant service customisation to match patient need, and delivery will be owned in each place, models of care will reflect the strategic approach agreed for Sussex.

We will need to develop governance and leadership structures to reflect the needs of the Sussex Integrated Care System (ICS) and new reporting arrangements to reflect the requirements of CCGs, PCNs, providers and regulators as the new operating model lands and delivery against the plan progresses.

Delivery planning

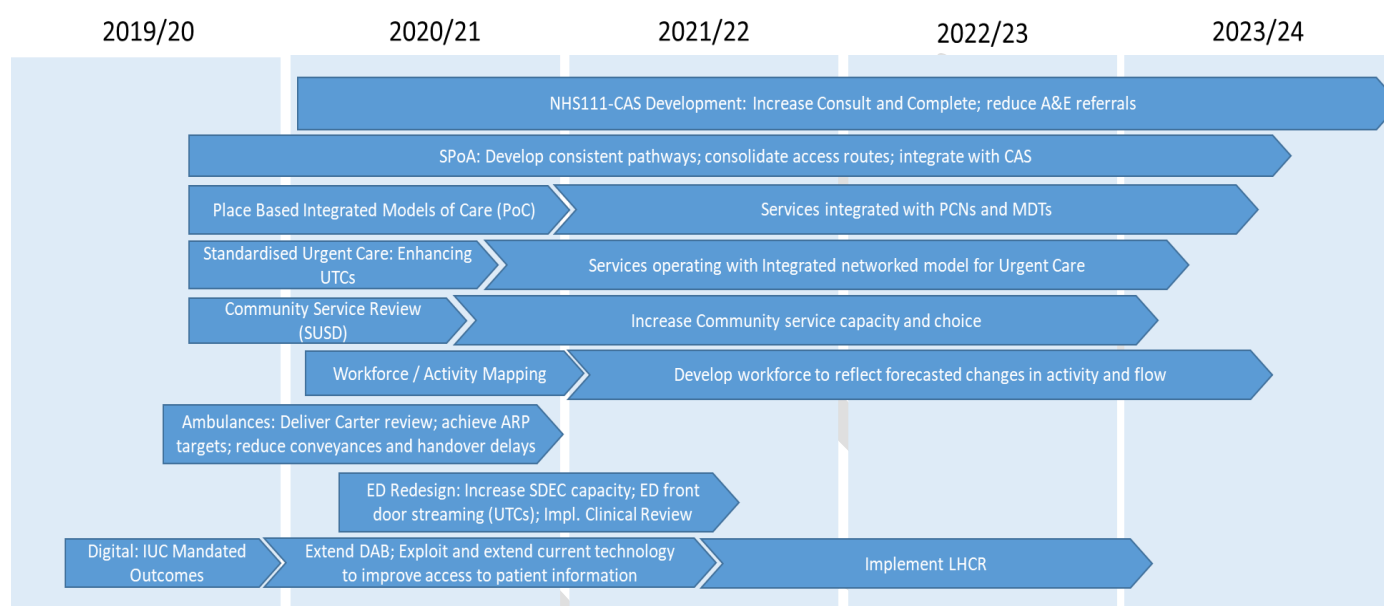A summary of our UEC transformation plan is shown in the figure below

Figure 35: Summary of our Sussex UEC transformation plan

Public engagement

The forward delivery of urgent and emergency care services is supported by an SHCP communications and engagement strategy, developed:

- To ensure patients have the information and support to make informed choices about their health care, providing them with a toolkit of options when they or a family member become unwell
- To increase positive awareness and understanding of the right services to use for the right health concerns – services to highlight include NHS 111/CAS, Urgent Treatment Centres, Integrated Primary and Community Service, GP Improved Access
- To increase positive awareness of other supporting services such as pharmacies, social care and third sector charities
- To encourage patients to use the appropriate service depending on their health care needs
- To reduce pressure in urgent care by promoting the ways in which minor illness can be treated at home
- To enhance patients' confidence and engagement in their local health care service, by offering consistency across the SHCP footprint to reduce current confusion.

All communications and engagement activity will be planned and delivered in a targeted way that maximises impact across the patient population.

Page 73 of 185

Digital enablers

Technology, system interoperability and our ability to share patient information appropriately are key factors in delivering the integrated services described for urgent and emergency care, and the trajectory to achieving the required level of digital maturity across Sussex is understood.

Work is already underway across the SHCP to make it possible to share patient data and care plans across different GP, hospital, ambulance and social care systems, exploiting existing infrastructures and technology.

Delivery of the Local Health Care Record (LHCR) will establish a strategic delivery mechanism to meet this challenge. However, full implementation is subject to funding, and remains dependent upon national solutions, such as GP Connect, which are required to deliver strategic solutions for access to structured patient data.

Focus will continue to be applied to gaining population insight using tools such as SHREWD to inform operational priorities and strategic direction, and identify system resilience pressures.

Workforce enablers

Workforce remains the biggest risk across the system. To mitigate this, the UEC strategy and plan is predicated on integrating services to remove duplication across pathways so that we can increase efficiency and productivity within our existing workforce.

Understanding the workforce needs of the future is dependent on having robust mechanisms for measuring the impact of services changes on activity and flow. Workforce models will be developed to measure and forecast our future needs to support our networked model for urgent care.

Priority will be given to developing a competencies-based approach to achieving the required patient outcomes. This will allow us to develop and enhance our existing workforce in advance of the longer-term role development, training and recruitment plans starting to take effect.

Further interventions will be determined and developed in the operational planning phases of implementation.

Estates enablers

The Estates Strategy has been developed with significant input from the Urgent and Emergency Care workstream to ensure future needs are reflected in capital investment projects. This is with regard both to the direct provision of UEC services and to the transformation of out of hospital and other enabling services that will contribute to the required changes in patient flow and the management of demand.

Estates Strategy priorities that specifically reference and support Urgent and Emergency Care, and services that the delivery of our networked model for urgent care depends on are as follows:

Page 74 of 185

1. Out of Hospital care
2. Urgent and Emergency Care services
3. Construction of BSUH 3Ts.

7.1.3. Giving people more control over their own health and more personalised care

At the core of our health and care strategic model is the role of personalised care in facilitating choice for our patients and population, who are often experts in their own care. They expect clear information about what treatment involves, the evidence that it works, the outcomes it will achieve, and what happens next. We believe in personalised care that means our population have choice and control over the way their care is planned and delivered, based on "what matters" to them and their individual strengths, needs and preferences.

The NHS Comprehensive Model of Personalised Care sets a clear ambition as to how we as a system can support patients by delivering tailored and truly personalised care. These actions are part of our comprehensive approach to prevention and reducing health inequalities across Sussex.

Component of NHS Comprehensive Model of Personalised Care	Actions to be taken
1. Shared decision making	Across our places, we are investing in and assessing the progress of sharing decision making, to ensure that our population understand their options and make an informed decision that reflects their personal preferences.
	At the heart of our approach of shared decision making is learning from existing shared decision making approaches in MSK and embedding them across all areas of elective care. Brighton & Hove are also embedding the Make Every Contact count approach in the shared decision making process, West Sussex are establishing shared decision making and working with the local authority, and East Sussex are utilising Patient Activation Measures (PAM).
2. Personalised care and support planning	We are working with local authorities to develop choice further, and discussions on preferences for future care are being built into pathways, with patients setting individual activation levels and goals. We will develop plans for Personalised Care and Support Planning with our local authorities, first identifying which patient cohorts and which pathways to prioritise in the first phase.
	Our aspiration to increase the number of active (new and reviewed) in-year Personalised Care and Support Plans (PCSP) over five years is set out in the Collections Tool.
3. Enabling choice, including legal rights to	Choice has been an integral part of our patient offer for a number of years, which we will continue to promote at the point of referral,

Page 75 of 185

	choice	including through the development of Single Referral Pathways and the Referral Support Service in West Sussex.
4.	Social prescribing and community-based support	We will seek to develop a coherent social prescribing approach that is aligned across each of our places, developing existing local initiatives in affiliation with community development organisations and aligned to the incoming social prescribing link workers at PCNs. We will have shared outcomes, while allowing for local flexibility to respond to specific population needs. In Brighton & Hove, for example, the established service is being expanded to include PCN link workers, and work is underway to embed social prescribing along the patient pathway. Our aspiration to increase the number of social prescribing link workers and social prescribing referrals over five years is set out in the Collections Tool.
5.	Supported self-management	Self-management is one of the building blocks of our health and care strategic model. Places will be reviewing the opportunities to collaborate with local authorities, ongoing projects and current patient pathways for greater development and integration of this principle in everyday delivery. Digital solutions are key to supporting self-management, with East Sussex looking at the utilisation of Patient Activation Measures (PAM) in service delivery to support self-management, and West Sussex using MSK Assist and myCOPD to support self-management.
6.	Personal health budgets and integrated personal budgets	Further plans are being developed with the local authority to increase the number of, and spend on, personal health budgets. This will build on work done around personal health budgets for wheelchairs, following on from work done with the local wheelchair provider. Our aspiration to increase the number of personal health budgets over five years is set out in the Collections Tool.

We are aware successful implementation of personalised care requires effective leadership and an upskilled workforce, so will be working with workforce leads and colleagues across Sussex to further understand the workforce implications and needs to support the implementation of personalised care. We also appreciate the importance of the first-hand experience of our population and will seek to identify further opportunities to co-produce personalised care with people with lived experience in Sussex.

More detail on the implementation of the six components of the NHS Comprehensive Model of Personalised Care can be found for each place in the Appendices.

Personalised care is a key component of our approach to services and, as such, we have also addressed our approach to personalised care throughout our plans. See sections 6.2.6 for our plans for personalised cancer care and sections 7.2.4 for our personalised care products developed as part of our digital programme.

7.1.4. Reducing waits for planned care

Across the Sussex footprint, we are committed to reducing the delays patients face when accessing elective care, including for musculoskeletal conditions. This has been one of the greatest challenges faced by our system, as the time that patients have waited for elective treatment during 2018/19 has increased and exceeded the 18-weeks RTT targets and diagnostic targets across a number of our places.

Our elective services are currently commissioned from a wide range of NHS and independent sector providers in the region, as well as supporting referral further afield. Therefore, we need to prioritise working with all these system partners to implement our planned care improvement programme.

As a system, we have tasked each place to set out their plans to improve planned care, based on the following common principles.

Planned care principle	Actions to be taken
Ensure compliance with the 52-week RTT target and increase volume of planned surgery	• Increase elective care activity • Work to meet the diagnostic standard through improvements in referral criteria and demand management, booking efficiencies, diagnostic capacity increases, and delivery of Rapid Diagnostic Services with the Cancer Alliance • Work to increase theatre productivity and efficiency
Reduce waiting lists	• Release and re-direct efficiencies to enable elective care to be delivered in the most appropriate setting, including in primary and community care • Implement referral management initiatives, including Advice and Guidance for GPs, reducing unwarranted variation in elective referrals demand and outcomes • Reduce length of stay through GIRFT opportunities and targeted initiatives such as BSUH's specific support for super stranded patients with alcohol/substance misuse • Minimise activity with limited clinical value in line with Clinically Effective Commissioning (CEC) programme and adherence to national evidence-based interventions
Improve patient choice	• Expand digital and online services to improve patient choice, including offering more virtual outpatient appointments • Mobilise Capacity Alerts to sign-post patients upon referral in Primary Care to where there are shorter waits for planned care within the system • Work together to ensure that the 26-week wait policy is

		fully implemented by April 2020, developing an SOP, sourcing capacity and setting up an admin hub, to commence with a small pilot in December 2019
Support self-management and empower patients	•	Scale up provision of First Contact Practitioners to enable faster access to diagnosis and treatment for people with musculoskeletal conditions and support more patients to effectively self-manage their conditions

Our plans for planned care aspire to change the profile of our planned care activity in Sussex, through our commitment to reduce face-to-face outpatient appointments and subsequently increase digital appointments, increase advice and guidance provision, and motivate activity shifts through implementation of 26-week wait choice policy. We do not yet have sufficient implementation detail to reflect this in current activity and finance modelling, but as we develop this we will reflect it in our overall activity and finance projections for Sussex.

Further detail on how we're addressing planned care challenges within MSK services is shown in section 6.5, alongside plans to reduce unwarranted clinical variation across the footprint. Additional detail on our plans to transform outpatient services are set out in section 6.1.5.

More detail on the implementation of planned care improvements can be found for each place in the Appendices.

7.1.5. Digital transformation of primary care and outpatients

Within the Sussex Health and Care Partnership, we believe that digital tools and new technologies will allow us to radically redesign how our local populations access and interact with their care. A key priority for us is the transformation of primary care and outpatient services to improve access and increase patient choice.

Primary care

The ambition set out in the LTP is for every patient to have access to online consultations by April 2020 and video consultations by 2021. Our intent is outlined below, with further detail provided as part of our Digital Ambition and plan in section 6.2, as well as in the Strategic Planning tool.

We have made a strong start towards achieving this goal, with East Sussex being an early adopter for a targeted Digital First primary care offer, co-designed with users and providers. The online consultations have a good uptake already, and the lessons learnt from this are being shared across the footprint to develop our standard offer.

Our goal is to offer a comprehensive portfolio of online consultations and triage, including video-based consultation, and we will support GP practices in tailoring this to meet their local needs. We recognise that GP practices will adopt and develop at different paces due to their local population demand, practice culture and the challenges they are facing.

We will draw on the lessons from our initial user-led co-design in East Sussex and the innovation and digital services developed locally across our system. For example,

developing the already well-regarded social prescribing offers from places and neighbourhoods and supporting them with strong digital offerings. In Adur & Worthing the digital offer is being co-designed and developed with the local authority on their low-code platform using their Same Room user-led design approach to meet the needs of citizens, clinicians and communities.

Outpatients

The NHS LTP includes an ambitious pledge to use technology to fundamentally redesign outpatient services over five years. The aim is to avert face-to-face consultations in order to provide a more convenient service for patients, free up staff time and save money against the expected growth in demand. This will reduce travel times for staff and patients, improve patient experience and reduce the carbon footprint of the system.

We will do this by increasing the use of digital tools to transform how outpatient services are offered and provide more options, better support, and properly joined-up care at the right time in the optimal care setting through virtual outpatient appointments. Over the next five years, patients will have the right to online 'digital' GP consultations, and redesigned hospital support will enable the digital transformation of up to a third of outpatient appointments.

We have already made progress:

- In 2019, Brighton & Hove piloted tele-ophthalmology using new technologies to change the approach to how we treat Age Related Macular Degeneration. This new approach enables specialist community optometrists to improve referrals, have them assessed remotely by hospital consultants and, where appropriate, provide review and routine follow-up without the patient needing to return to the hospital.
- In Eastbourne, Hailsham & Seaford, and Hastings & Rother, digital enablers have been used for managing diabetes correspondence and self-management.
- In West Sussex, our providers will all complete implementation of their first stage of digital outpatients, deploying access to letters and appointments through a Sussex-wide Personal Health Record solution.
- Across Sussex, we have delivered successful virtual clinics and digital offerings in fracture clinics, IBD and HIV services.

Further plans are in place:

- In Brighton and Hove, we are supporting development of primary care based tele-dermatology, allowing images and case symptoms to be reviewed by specialists prior to referral. This pre-referral review means many conditions can, using specialists' advice and guidance, be treated in the community without a visit to the hospital outpatient departments.
- In East Sussex, schemes such as Patient Knows Best and Virtual Fracture Clinics are looking to improve efficiency and the initial focus will be on ophthalmology, gynaecology, and urology. Plans are in progress to choose applications for virtual outpatient appointments after which specialties will be chosen.
- In West Sussex, we will deliver programmes around ophthalmology, urology, neurology and gastroenterology, expanding this to a Digestive Diseases programme in 2020-21.
- Phase 1 of the 3Ts Build Programme will support, and be supported by, outpatient transformation and new models of care.
- Plans are in place to establish a programme of work which will see the implementation of one-stop and straight-to-test pathways, virtual clinics, SOS follow-

Page 79 of 185

up, and the use of alternatives such as telephone or Skype.

- We are developing the PHR-based Personalised Care Product offerings for risk stratified cancer follow-ups in breast, colorectal and prostate which, following successful tests in the system, will be expanded to all of Sussex over the next five years.

However, we are aware that these developments need strengthening and coordinating across the system to ensure the impact is maximised. Therefore, an outpatient workshop was set up in September 2019 with 28 representatives from NHSE/I, trusts, CCGs and the Partnership, to develop local action plans to enable the delivery of outpatient transformation across Sussex.

The local vision was defined as "*having the right clinicians, the right place to treat the patient, and the right outcomes against which to measure treatment where patients do not have to attend an outpatient appointment unless absolutely required to do so*".

A number of further priority initiatives were identified, and suggestions developed for proposed next steps which will deliver our model for transformation of outpatient services.

Priority initiative	Proposed next steps
Analytics Partnership to utilise and embed data analytics in day-to-day management of outpatient care	• Baseline assessment of current digital maturity and delivery plans to understand mid/short/long term opportunities • Greater transparency in data sharing between CCGs, providers and the Partnership • Investment in data analytics skills training • Improved integration of IT systems and investment in IT performance capabilities to identify priority patients using risk stratification • Consideration of ways to measure success (such as appraisals) which include a data metric
Pathways Champion key tenets of pathway development across the local area	• Further work with providers and commissioners to establish which pathways could be most effectively redesigned • Partnership championing of pathways and support for a pilot / promotion of outcomes • Identification of and learning from best practice elsewhere using NHS England Elective online platform
Remote care Support organisations who are keen to employ remote care alternatives to traditional outpatient appointments	• Investment in systems/processes that could increase the number of patients able to access remote care • Partnership championing of and support for the piloting of several types of virtual clinic • Feeding back of outcomes / cascade across Sussex

Accountability and governance Partnership to act as a system leader to coordinate the changes across the system	• Governance group review/confirmation as priority initiative and allocation of resource to undertake key activities
Patient expectations Have honest conversations to manage patient expectations at a strategic level	• Involvement of Healthwatch in any strategic initiatives relating to patient communications • Creation of a Patient Public Representation (PPI) group which has a specific interest in outpatients • Development of an engagement plan
Building networks Forge operational links between mental health, community care and primary and secondary care clinicians	• Consideration of a reference group or consultation forum which covers all key groups
Models of commissioning	• Consideration of Aligned Incentive Contracts as a useful way of moving forward • Tariff and/or costings nationally to incentivise transformation shift from face-to-face to virtual appointments or reduce the need for appointments

Workshop participants agreed on the need for a **Sussex Outpatient Transformation Board to own the transformation**, working with the **three places and the Cancer Alliance on local action plans**. Clinical leadership, engagement and participation, and patient representation are essential to the transformation work and so a **programme plan and engagement strategy will be developed**.

The immediate focus will be place-based, targeted redesigns for emerging priorities offering virtual clinics, patient-initiated pathways, and self-management and self-monitoring support.

7.2. Improving cancer outcomes

Our aim as a system is to improve early diagnosis rates, timely diagnosis and treatment, and to support our population to manage their own health and wellbeing through more personalised care, whilst ensuring that all care delivered is of the highest quality. Cancer is both a national and a local priority, which is why we are working towards national targets, as laid out in the NHS constitution and Surrey and Sussex Cancer Alliance (SSCA) plan, to be

delivered through local solutions across Sussex.[8]

7.2.1. Current state and challenges

The Sussex and East Surrey Cancer Board was constituted in July 2019 with the purpose of providing system-wide leadership and accountability for the delivery of transformational change across Sussex. The Board also oversees the delivery of plans and the achievement of the strategic objectives agreed by SSCA and STP Cancer Programme, and will play a key role in driving forward our strategy and achieving the ambitions of the Long Term Plan.

The Long Term Plan set out two bold ambitions for improving cancer outcomes which we are focused upon achieving:

- By 2028, 55,000 more people will survive cancer for five years or more each year
- By 2028, 75% of people will be diagnosed at stages 1 or 2.

The Sussex Health and Care Partnership has made recent progress against these metrics and other important indicators of cancer care, although there is still significant room for improvement:

- The proportion of cancers diagnosed at stage 1 or 2 has improved in Coastal West Sussex (CWS), Eastbourne, Hailsham & Seaford (EHS) and High Weald Lewes Havens (HWLH) with small reductions in other CCGs
- The one-year survival rate has improved across all CCGs comparing 2014 to 2016, with the largest improvement in Crawley CCG
- Patient rating of overall care has improved in all CCGs apart from Brighton & Hove and Crawley CCGs.

However, the ambitions are stretching, and we recognise that we face challenges in meeting them and in delivering the best possible care and outcomes for our whole population, as we are not currently consistently achieving national targets for two week waits or 62 day performance.

---

[8] See Surrey and Sussex Cancer Alliance, 'System Ambitions 2019-2024' for greater detail on all of our cancer programme areas. The Partnership is committed to working closely with SSCA to deliver on their five year system ambitions and specific programmes.

Early diagnosis – rolling one year average

Average of 1 Year Average (%)			
	2017 - Q3	2017 - Q4	2018 - Q1
England	52.1	51.9	51.8
NHS Brighton and Hove CCG	53.7	52.7	51.3
NHS Coastal West Sussex CCG	53.5	54.4	55.9
NHS Crawley CCG	52.8	50.5	52.1
NHS Eastbourne, Hailsham and Seaford CCG	49.5	51.1	51.9
NHS Hastings and Rother CCG	51.5	51.5	50.9
NHS High Weald Lewes Havens CCG	50.3	51.7	51.3
NHS Horsham and Mid Sussex CCG	48.9	48.3	48.4
Grand Total	**52**	**52**	**52**

Figure 36: Early diagnosis rolling one year average

One year survival

	Year of diagnosis		
	2014	2015	2016
England	71.5	72.2	72.8
NHS Brighton and Hove CCG	69.8	70.7	71.4
NHS Coastal West Sussex CCG	71.5	72.3	73
NHS Crawley CCG	70.4	70.6	72.1
NHS Eastbourne, Hailsham and Seaford CCG	70.6	71.1	71.8
NHS Hastings and Rother CCG	69.4	70.1	70.9
NHS High Weald Lewes Havens CCG	71.7	72.2	73.1
NHS Horsham and Mid Sussex CCG	73	73.8	74.5
Grand Total	**567.9**	**573**	**579.6**

Figure 37: One year survival rate

Page 83 of 185

National Cancer Patient Experience Survey (CPES)[9]

The average rating given by respondents when asked to rate their care on a scale of 0 (very poor) and 10 (very good) is shown below.

	B&H	CWS	Craw.	EHS	H&R	HWLH	HMS
2018	8.6	8.9	8.7	8.9	8.8	8.7	8.7
2017	8.7	8.9	8.5	8.8	8.9	8.9	8.6
2016	8.7	8.7	8.8	8.7	8.7	8.6	8.6

Figure 38: NCPES results from 2016-2018

2 week wait[10]

	Seen within 14 days	Seen after 14 days	Total seen	Performance	Performance Target
2019-20	6,036	526	6,562	92.0%	93.0%

Figure 39: two week wait performance

31 day standard

	First Treatment within 31 days	First Treatment after 31 days	Total First Treatments	Performance	Performance Target
2019-20	899	29	928	96.9%	96.0%

Figure 40: 31 day performance

62 days urgent GP referral

	First Treatments within standard	First Treatments after standard	Total First treatments	Performance	Performance Target
2019-20	438	144	582	75.3%	85.0%

Figure 41: 62 days urgent GP referral performance

---

[9] www.ncpes.co.uk

[10] Two week wait, 31 day standard and 62 day standard data, www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times

Page 84 of 185

62 days screening

	First Treatments within standard	First Treatments after standard	Total First treatments	Performance	Performance Target
2019-20	65	12	76	84.9%	90.0%

Figure 42: 62 days screening performance

With regards to screening and early diagnosis across Sussex, we perform worse than average in some areas and have significant variation between CCGs. Reducing this inequity of outcome is a key priority for our system as, across Sussex:[11]

- Bowel screening uptake ranges between 52.5% in Crawley and 63.0% in Horsham & Mid Sussex, against an English average of 57.3%
- Cervical screening uptake ranges between 68.2% in Brighton & Hove and 76.9% in Horsham & Mid Sussex, against an English average of 71.7%
- Breast screening uptake is furthest below the England average, as uptake ranges between 65.9% in Brighton & Hove and 72.2% in Coastal West Sussex, when the England average is 72.1%
- Sussex also performs lower than the national average for cancer staged (79.2% vs. 81.4%), and SSCA is the second lowest alliance in the country for cancer stages (2017 data)
- One-year survival ranges between 70.9% in Hastings & Rother and 74.5% in Horsham & Mid Sussex, compared to an English average of 72.8%.

7.2.2. **Five-year vision and key delivery priorities**

We share the vision of SSCA to develop and deliver world-class outcomes in cancer care and treatment for our population through greater integrated and personalised care over the next five years. We are working towards key national targets to:

- Significantly improve one year survival to achieve 75% by 2020 for all cancers combined
- Ensure that 95% of patients are given a definitive cancer diagnosis, or an all-clear, within 28 days of being referred by a GP, and 50% within 14 days.

To achieve our ambitious plans for future cancer care, we need to shift our focus towards reducing health inequalities through supporting our whole population to manage their health and wellbeing. Through online feedback and a series of workshops, SSCA has collaboratively agreed the top priorities for the Alliance which Sussex are committed to delivering.

---

[11] Data on screening rates, Fingertips, fingertips.phe.org.uk/profile/cancerservices/data
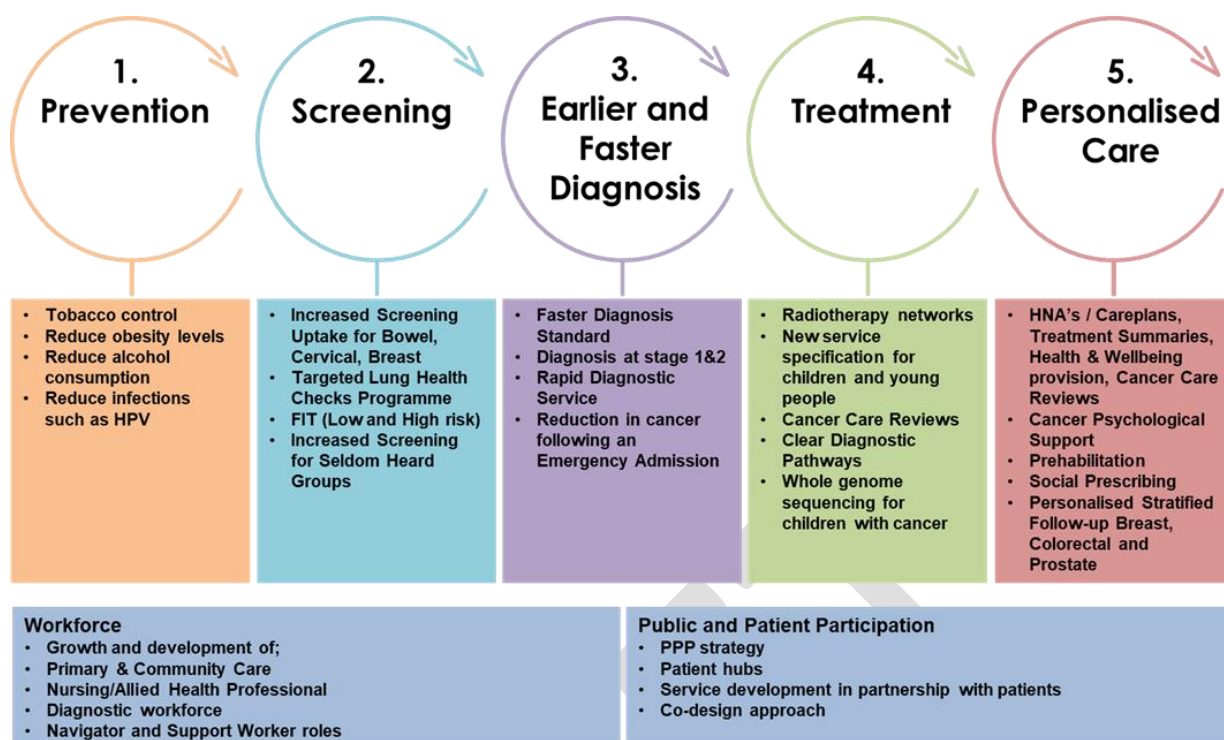
Figure 43: Key delivery priorities for cancer

7.2.3. Prevention

Our lifestyle choices affect our risk of developing cancer. Up to half of all cancer could be prevented by changes in lifestyle behaviours, so we recognise the need for a new approach to improve our public's health which will support cancer prevention efforts. If we are to tackle the health problems caused by smoking, poor diet, obesity, alcohol misuse and lack of exercise effectively, we need a whole system approach. Therefore, we will collaborate with the newly-formed Sussex Partnership Prevention Board and engage closely with the other Integrated Care Systems (ICSs) within SSCA to share learnings.

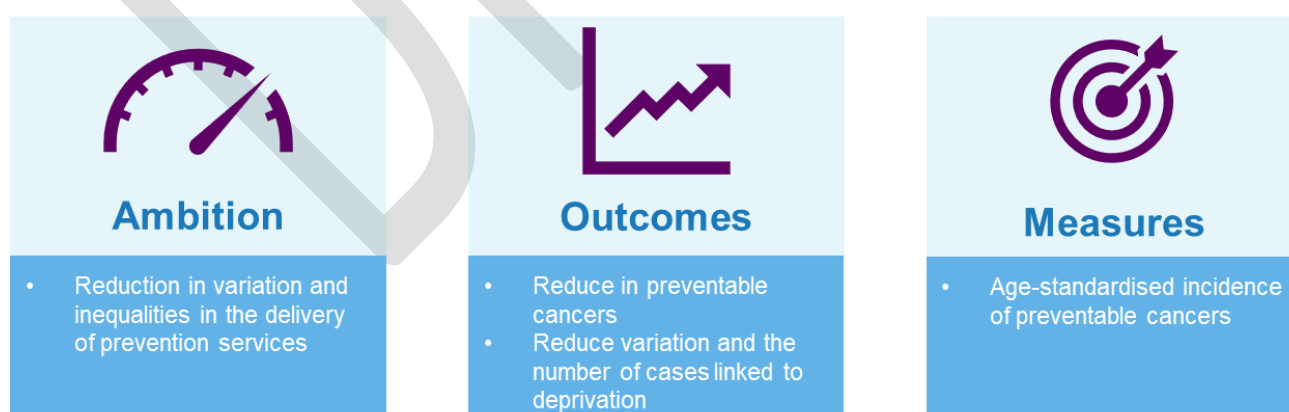
Figure 44: Our ambition, outcomes and measures to address preventable cancers

Closing the gap

Work is underway by the Partnership Cancer Early Intervention Project managers to review the inequalities across the region and to prioritise cohorts of patients where it is felt that the most impact can be achieved through interventions to increase screening uptake, linking to

Page 86 of 185

deprivation and one year survival rates.

Making Every Contact Count

We support the system wide roll-out of 'Making Every Contact Count' (MECC) as a core training priority. The training provides the skills for any member of staff to confidently initiate a conversation about health behaviour change and to effectively signpost to supporting lifestyle services (via the MECC application which has been adopted by the local authority and wider Sussex Partnership). From 2020/21 the MECC approach will be used within the Rapid Diagnostic Services to encourage those patients who have not been diagnosed with cancer to participate in screening if eligible.

Raising awareness

SSCA will continue to support the national 'Be Clear on Cancer' programme and, within Sussex, we will raise awareness of cancer and prevention through:

- Community Ambassadors across Sussex.
- Public Health smoking cessation services. For more information, please see section 6 on Prevention and Appendix A.
- Drink Coach, a skype-based coaching service for those seeking to reduce their alcohol intake. Please see section 6 on Prevention for more detail and programme scoping.
- 'Active for Life' and equivalents in local authorities, commissioned activity such as 'Speak Up' provided by Albion in the Community in Brighton & Hove, 'One You' in East Sussex and other health/wellbeing coaching initiatives locally.
- Supporting the extension of the HPV vaccination programme to boys in school in year 8.

Over the past four years, the number of patients seen on a two week wait pathway has increased, and the data demonstrates that national campaigns have prompted some of this rise, but increases are also experienced outside of 'Be Clear on Cancer' campaigns which could be due to the lagged effect of campaigns or other factors.
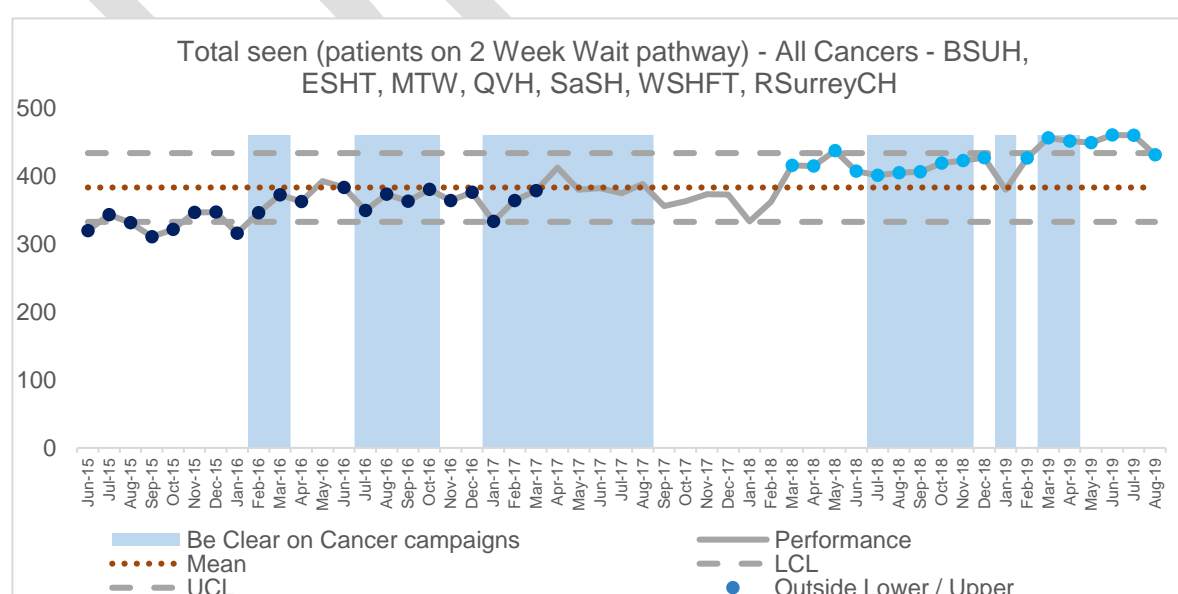

Figure 45: Patients on two week wait pathway

Page 87 of 185

7.2.4. **Screening**

To achieve our ambition of increasing the proportion of cancers diagnosed at early stages, increasing the effectiveness and uptake of our range of screening programmes is vital.
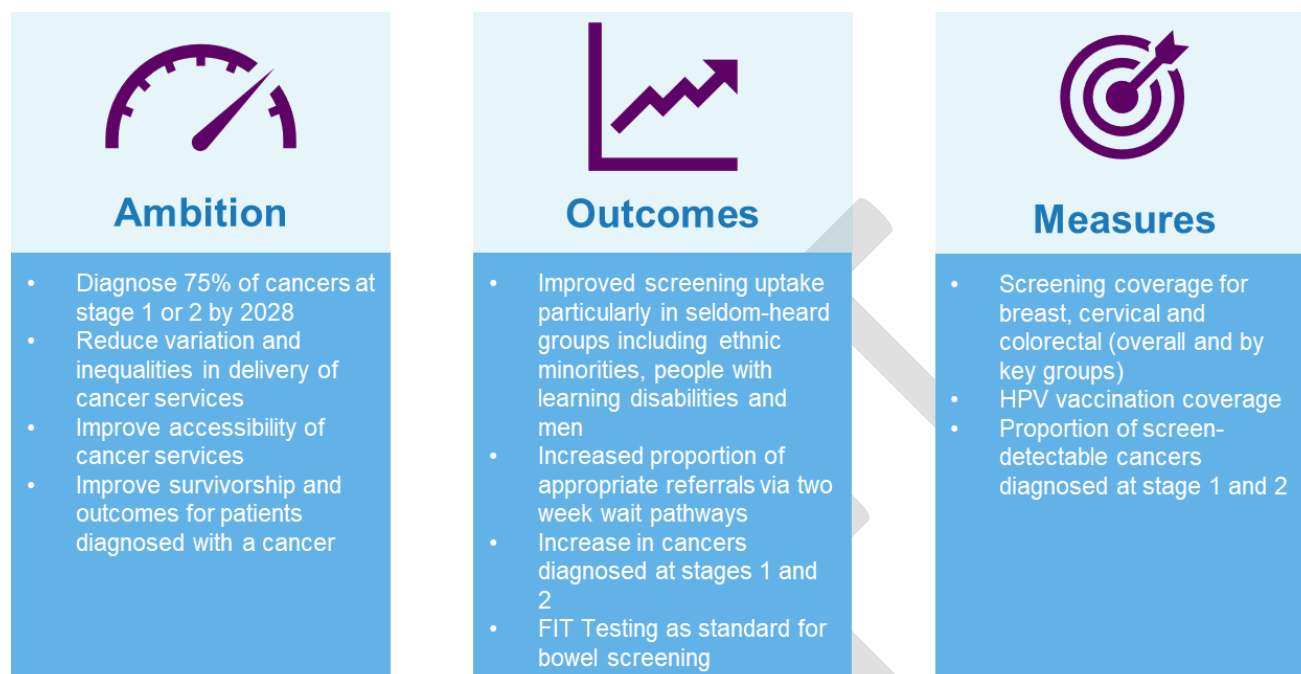

Ambition

- Diagnose 75% of cancers at stage 1 or 2 by 2028
- Reduce variation and inequalities in delivery of cancer services
- Improve accessibility of cancer services
- Improve survivorship and outcomes for patients diagnosed with a cancer

Outcomes

- Improved screening uptake particularly in seldom-heard groups including ethnic minorities, people with learning disabilities and men
- Increased proportion of appropriate referrals via two week wait pathways
- Increase in cancers diagnosed at stages 1 and 2
- FIT Testing as standard for bowel screening

Measures

- Screening coverage for breast, cervical and colorectal (overall and by key groups)
- HPV vaccination coverage
- Proportion of screen-detectable cancers diagnosed at stage 1 and 2

Figure 46: Our ambition, outcomes and measures to improve uptake of screening

Closing the gap

Targeted interventions

Local targeted interventions will be funded through Cancer Alliance transformation funding to improve performance across low uptake areas including Crawley, Horsham & Mid Sussex, and East Sussex. The interventions will be rolled out, evaluated, and any learning shared across the Alliance region to inform future targeted interventions over the next four years.

Alongside specific provider programmes to improve uptake of bowel, breast and cervical screening (please see Appendix A for more detail), we are raising public awareness of these programmes and working with partners such as Public Health to target inequalities for service users by supporting access for those with learning disabilities and the homeless.

Local Screening and Immunisation Leads will offer direct support on implementation, whilst NHSE will lead the development of public communications campaigns aimed at increasing uptake, particularly for underserved populations, and targeting inequalities. The joint screening forum led by Public Health England (PHE) and the Cancer Alliance will support sustainability of interventions by gathering and sharing intelligence to undertake a joint planning approach.

FIT

FIT testing commenced in early June 2019 and early evidence indicates an increased uptake compared to the previous **Guaiac** Fecal Occult Blood Test (gFOBT) method. PHE

Page 88 of 185

will work to support our providers with capacity planning for the increases in activity expected as a result of the increased uptake and positivity about the new test, as well as the reduction of the starting age from 60 to 50.

Primary care

From April 2020, the Primary Care Network DES will put responsibility onto Primary Care Networks to improve earlier diagnosis, likely through an involvement in improving cancer screening uptake. Details of the exact specification of the DES are due in early 2020. We will continue to collaborate closely with our third sector partners, including Cancer Research UK (CRUK) who will continue to support Sussex practices by checking GP endorsement on bowel screening patient letters; showing bowel screening videos in practice waiting rooms; setting up practice alert systems for non-responders to enable opportunistic conversations on screening; contacting non-responders for screening; and engaging community groups in order to improve uptake.

SCCA and Sussex

Over the next five years, Sussex Partnership will work with SSCA to improve uptake and reduce variation across the region by:

- Developing a workforce initiative with HEE and local STPs/ICSs to ensure that the necessary workforce is both available and appropriately trained to deliver the programmes over the next five years
- Drawing from the national review to assess opportunities for the use of artificial intelligence and stratification in screening, and likely timescales and implementation approach
- Reviewing the findings of SSCA's evaluation of current local initiatives as well as national work undertaken to inform strategic planning on how best to maximise uptake of screening
- Integrating research and evaluation within screening on an ongoing basis
- Ensuring that the screening initiatives in the Alliance region support the wider efforts being made to promote early diagnosis of cancer
- Linking with other work programmes underway to ensure that approaches to increasing diagnostic capacity both for screening and symptomatic diagnosis of cancer are joined-up.

For specific actions being undertaken by CCGs and providers, please see Appendix A.

Earlier and faster diagnosis

Earlier diagnosis is critical to meeting our survival ambition, as it means patients can receive treatment when there is a better chance of achieving a complete cure. These improvements will come from a range of screening optimisation, targeted screening, better pathways, translation of research into treatment, and support for timely presentation by the public.
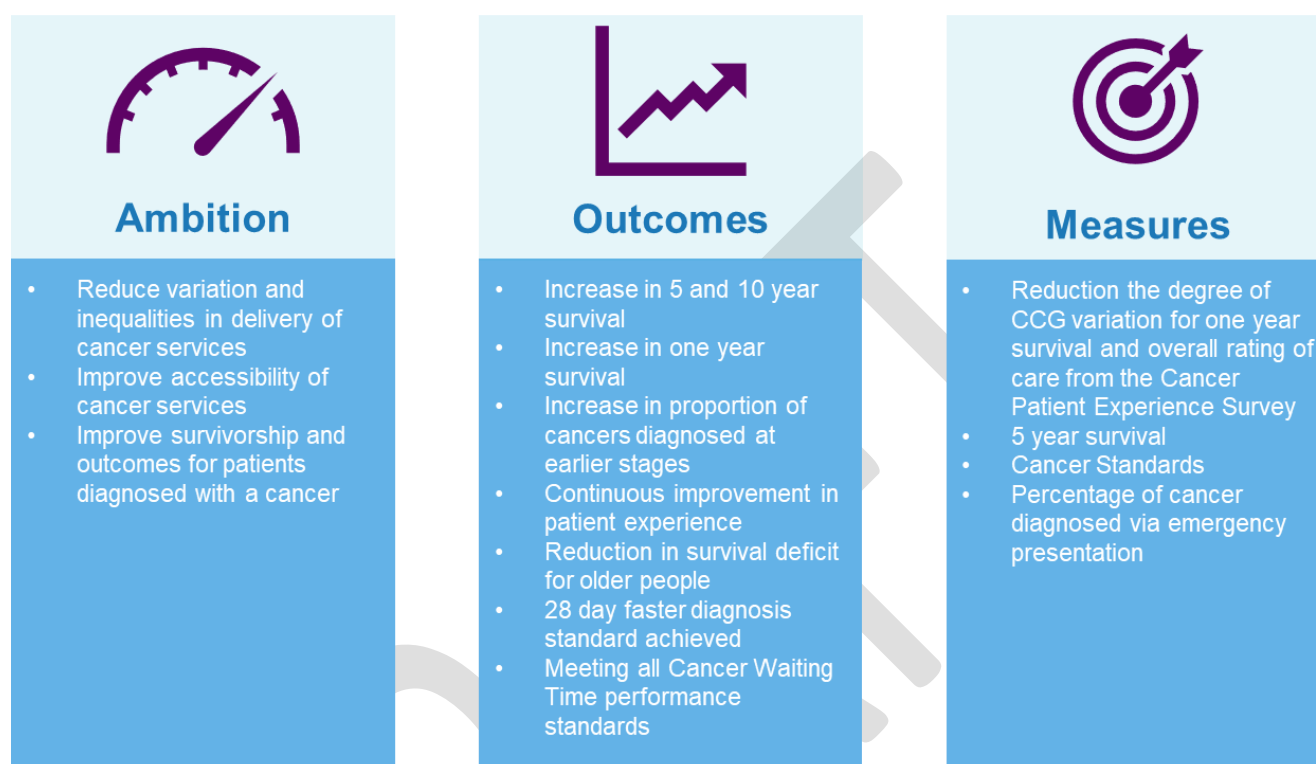
Ambition

- Reduce variation and inequalities in delivery of cancer services
- Improve accessibility of cancer services
- Improve survivorship and outcomes for patients diagnosed with a cancer

Outcomes

- Increase in 5 and 10 year survival
- Increase in one year survival
- Increase in proportion of cancers diagnosed at earlier stages
- Continuous improvement in patient experience
- Reduction in survival deficit for older people
- 28 day faster diagnosis standard achieved
- Meeting all Cancer Waiting Time performance standards

Measures

- Reduction the degree of CCG variation for one year survival and overall rating of care from the Cancer Patient Experience Survey
- 5 year survival
- Cancer Standards
- Percentage of cancer diagnosed via emergency presentation

Figure 47: Our ambition, outcomes and measures to diagnose cancer earlier

Closing the gap

We are implementing the faster diagnosis standard and pathways across our whole Partnership to deliver quicker and safer care that reduces variation across Sussex. This is also the aim of the South of England Imaging Programme in the face of 12% year on year demand increases for services as well as ageing equipment. Through establishing an imaging network serving Surrey and Sussex, this will reduce variation across the service in order to drive efficiencies, expand capacity, enable equipment and estate investment, and deliver new ways of working in a sustainable service.

Rapid Diagnostic Services

The commitment to roll out Rapid Diagnostic Services (RDS) forms an important part of our broader strategy to deliver faster and earlier diagnosis, as measured by the new Faster Diagnosis Standard (FDS) from April 2020 and improved patient experience. Significant service changes, such as Rapid Diagnostic Services, will be vital in treating the number of people diagnosed with cancer which is expected to rise by 29% between 2016-2028. RDCs will also complement work to improve screening programmes, augment the potential of artificial intelligence (AI) and genomic testing, and utilise PCNs to improve early diagnosis in their localities.

Page 90 of 185

By implementing RDSs, we aim to contribute to the following objectives:

- To support **earlier and faster cancer diagnosis** by assessing patients' symptoms holistically and providing a tailored pathway of clinically relevant diagnostic tests as quickly as possible, targeting and reducing any health inequalities that may currently exist
- To create increased capacity through **more efficient** diagnostic pathways by reducing unnecessary appointments and tests
- To deliver a **better, personalised diagnostic experience** for patients by providing a series of coordinated tests and a single point of contact
- To **reduce unwarranted variation** in referral for and access to relevant diagnostic tests, as well as in the tests' reliability, by setting standards for RDCs nationally, mandating consistent data collection to enable benchmarking, and providing regional support to roll out RDCs
- To **improve the offer to staff** with new roles which offer development opportunities, greater flexibility and a chance to work in innovative ways.

SSCA are aiming for a service provision rather than a fixed centre and are currently exploring virtual and face-to-face models which may differ in format between localities. The Alliance has completed a Capacity and Demand analysis of imaging modalities and endoscopy, and have used this data to inform our option appraisal for service delivery.

7.2.6. Treatment

Advancements in technology and clinical innovation mean that new and more effective treatment options are becoming available. We must ensure that, across Sussex, we maximise the impact of these opportunities to manage treatment of cancer to improve survival and quality of life outcomes.
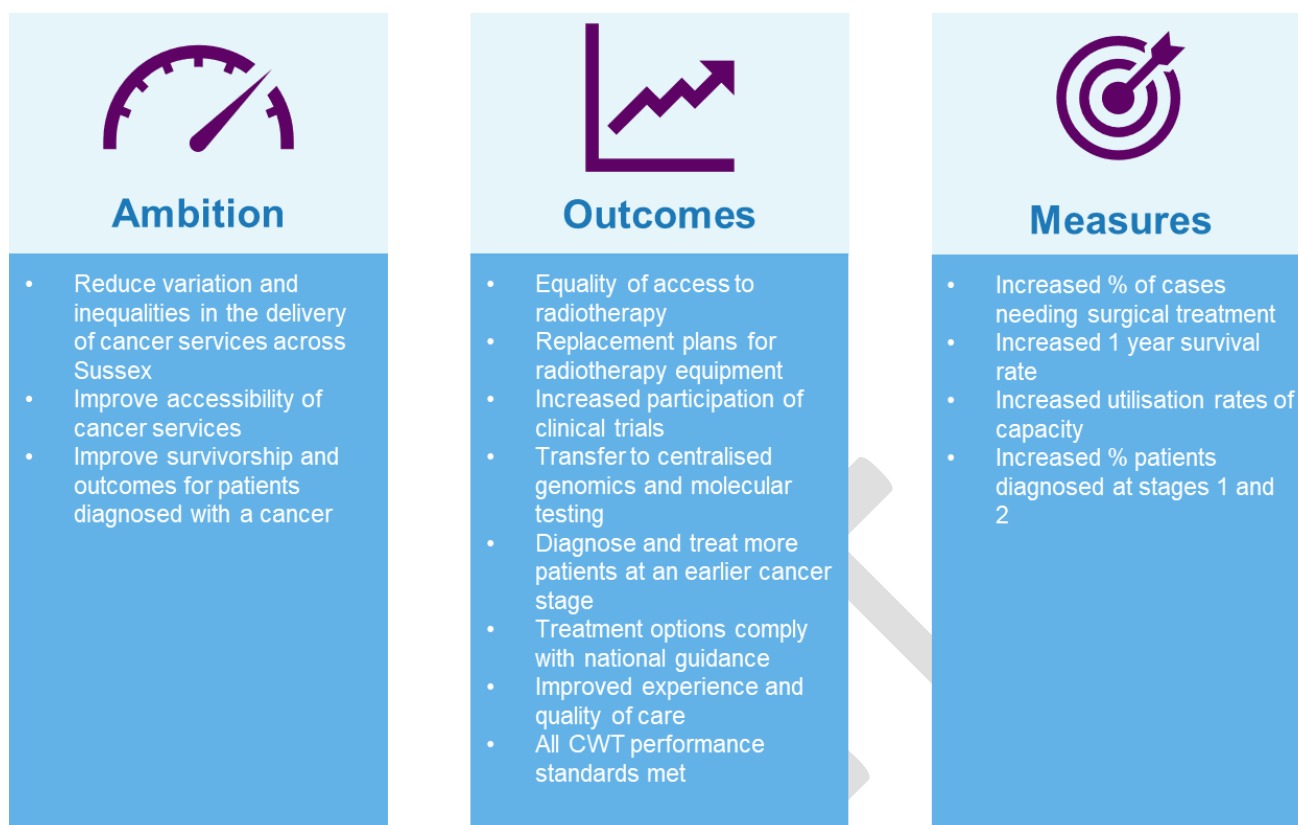
Ambition
- Reduce variation and inequalities in the delivery of cancer services across Sussex
- Improve accessibility of cancer services
- Improve survivorship and outcomes for patients diagnosed with a cancer

Outcomes
- Equality of access to radiotherapy
- Replacement plans for radiotherapy equipment
- Increased participation of clinical trials
- Transfer to centralised genomics and molecular testing
- Diagnose and treat more patients at an earlier cancer stage
- Treatment options comply with national guidance
- Improved experience and quality of care
- All CWT performance standards met

Measures
- Increased % of cases needing surgical treatment
- Increased 1 year survival rate
- Increased utilisation rates of capacity
- Increased % patients diagnosed at stages 1 and 2

Figure 48: Our ambition, outcomes and measures to improve treatment of cancer

Two week wait performance varies across the Partnership, but variation is much more significant against the 62 day wait target where we perform below both the national and SSCA averages. It is, therefore, a key priority for Sussex to drive improvement against these standards including learning from high performing CCGs and within the Alliance.
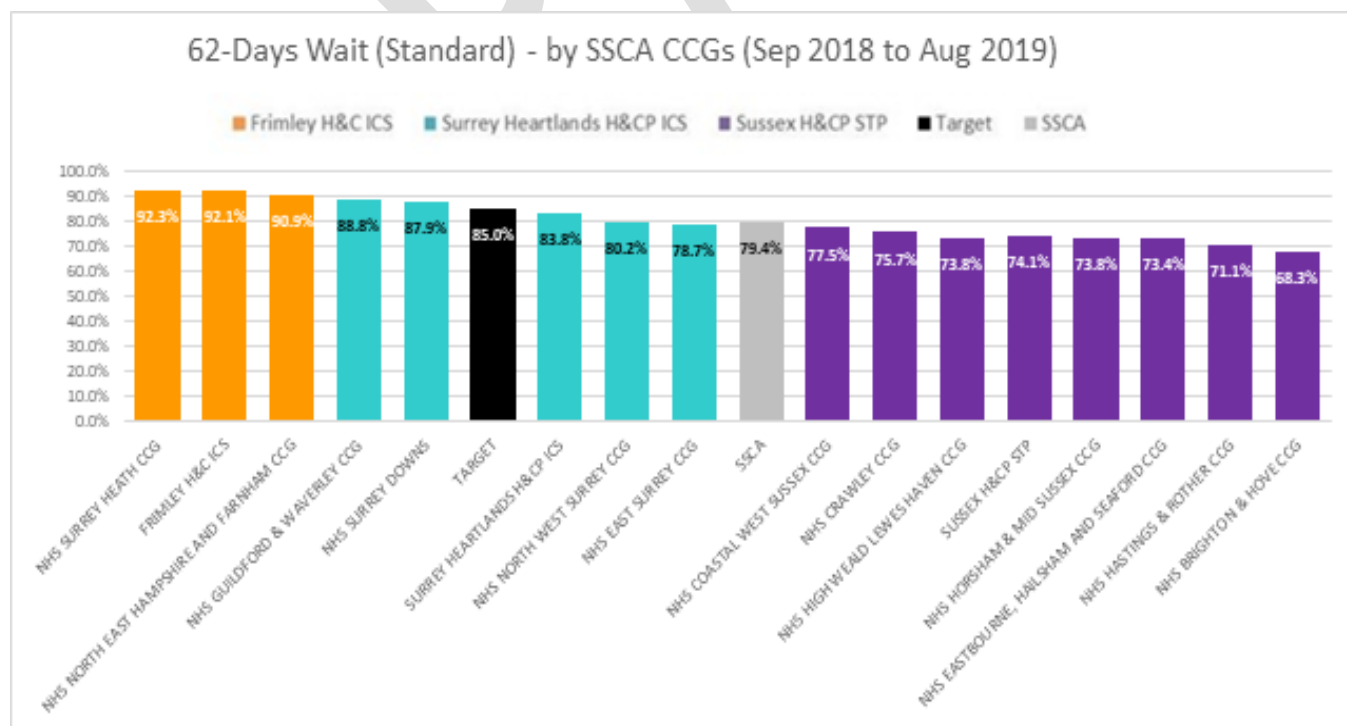

Figure 49: Performance against 62 day target

There are a range of factors which affect one year survival rates detailed below. For specific actions being taken by individual trusts and CCGs to address these factors, please see Appendix A and place-based plans in Appendices B, C and D.

Stage at diagnosis	Treatment with curative intent	Patient factors
Stage at diagnosis	Surgery	Co-morbidity and fitness
Patient delay	Radiotherapy	Age
Doctor delay	Chemotherapy	Health-related behaviours
System delay	Immunotherapy	Social and economic determinants
	Cancer drugs	
	Coordination of treatment	

Figure 50: Factors affecting one year survival rates

Closing the gap

Recovery plans to achieve cancer waiting time targets

BSUH	• Individual tumour site recovery plans in place • Additional evening and weekend sessions in place in US/CT/MRI • Additional endoscopies • Lower GI and Upper GI are utilising any theatre capacity at short notice • Daily and Weekly escalation and patient level management enhanced • Ongoing exploration of virtual clinics and stratified pathways • Secured additional funding from SSCA for administrative support for performance improvement and for upper and lower GI triage nurses
ESHT	• New colorectal pathway incorporating FIT for high risk patients and STT (endoscopy) implemented February 2019. Colonoscopy reduced by 15%-20%. • Urology Investigation Suite opened in June, one stop service • Radiology capacity and demand gap analysis underway • Detailed capacity and demand review underway • Optimising capacity e.g. straight-to-test and telephone follow-ups • Secured additional funding from SSCA for FDS trackers, lung rapid diagnosis matron, upper GI triage nurse
MTW	• Action plans for each tumour pathway in development • Breast clinics to be re-mapped and additional capacity sourced • Increased imaging capacity sourced • Additional triage in secondary care so that patients with the highest suspected risks of cancer be transferred to alternative pathways • Daily huddles to identify patients that need to be expedited through the system for lower GI, upper GI, breast, urology, gynaecology, lung and haematology • Additional one stop clinic capacity for prostate, breast and lung pathways • Introduction of "straight-to-test pathways" for prostate, lung and breast • Test phase for the implementation of qFIT for low risk suspected colorectal cancer (Jan 2020)
WSHFT	• Action plans to implement 28 day FDS across all tumour sites (with an initial focus on 7 day first outpatient appointment) • Recruitment of 28 day FDS pathway trackers to enhance daily tracking and drive improvements in all tumour sites • Implementation of colorectal FIT 'low risk' (DG30) Oct 2019 and plans developing around FIT pilot in 'high risk' from Nov 2019 • Sustaining improvements in optimal pathways for colorectal and prostate ongoing • Implementing pathway improvements, Head & Neck one stop service and gynaecology fast-track pathway across hospital sites • Additional diagnostic capacity (radiology and histopathology) and reduced diagnostic reporting times • Renewed focus on lung ACE pathway

Radiotherapy and chemotherapy

RM Partners are hosting the nationally mandated Radiotherapy Operational Delivery Network (ODN) to deliver the national specification for Radiotherapy services published in January 2019. The ODN covers West London, Surrey and Sussex, and contains four radiotherapy centres (Imperial, Royal Marsden, Brighton and Sussex University Hospital and Royal Surrey Hospital). A work plan has been developed and agreed with NHS England and we will work with Specialist Commissioning to implement this.

Chemotherapy commissioning currently falls under specialist commissioning at a provider level and demand is expected to increase as we diagnose cancers more frequently and at earlier stages. SSCA have proposed a gap analysis to predict required workforce and physical estates space for delivery, including possible community based care.

Research and innovation

In order to meet national and local expectations regarding cancer research activity, we will

Page 94 of 185

build upon existing relationships with research partners including the Academic Health Science Network, the National Institute of Health Research, and other partner organisations including the University of Surrey and the University of Sussex.

7.2.7. Personalised care

By 2030, it is estimated that there will be around four million people living with cancer across the UK. Support for our population living with and beyond cancer needs to be centred on the individual and delivered at the right time, in the right way. We are committed to supporting patients in personalised care planning across Sussex so that by 2021, where appropriate, every person diagnosed with cancer has access to personalised care including a full assessment of their needs, an individual care plan and information to support their wider health and wellbeing. This will link into and complement the social prescribing models being developed at place across Sussex.
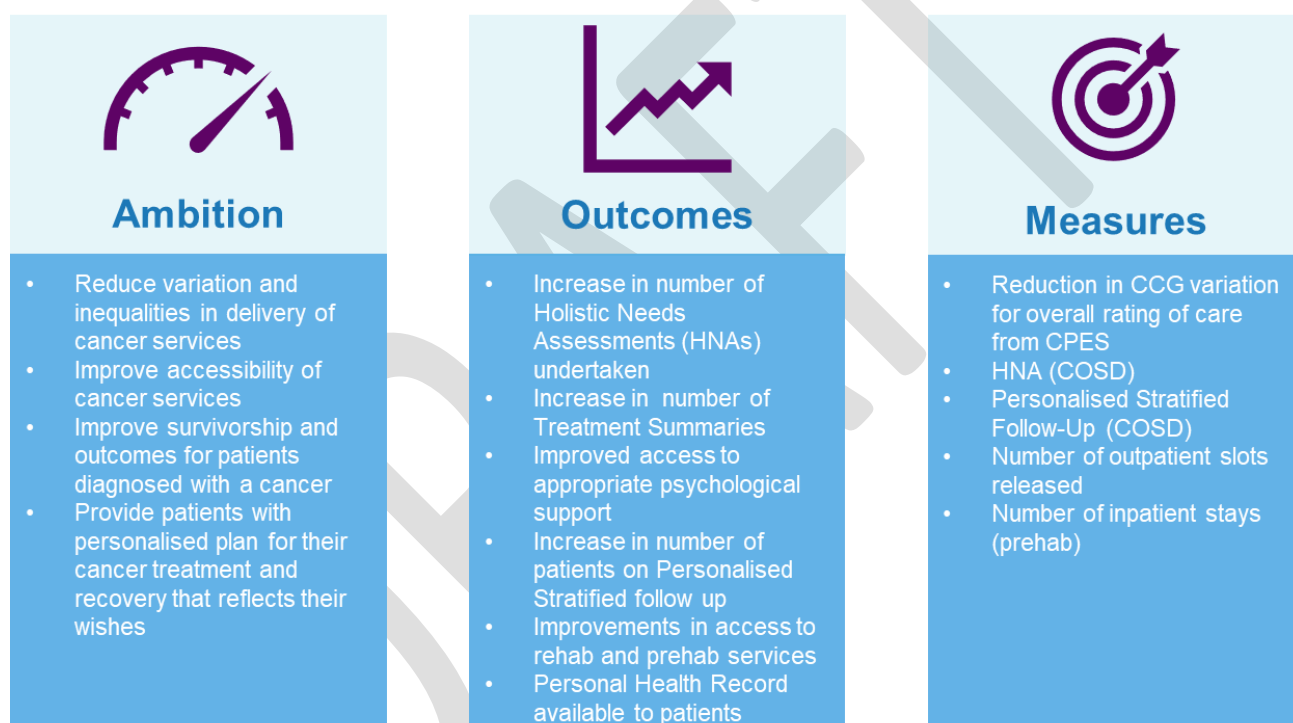
Ambition
- Reduce variation and inequalities in delivery of cancer services
- Improve accessibility of cancer services
- Improve survivorship and outcomes for patients diagnosed with a cancer
- Provide patients with personalised plan for their cancer treatment and recovery that reflects their wishes

Outcomes
- Increase in number of Holistic Needs Assessments (HNAs) undertaken
- Increase in number of Treatment Summaries
- Improved access to appropriate psychological support
- Increase in number of patients on Personalised Stratified follow up
- Improvements in access to rehab and prehab services
- Personal Health Record available to patients

Measures
- Reduction in CCG variation for overall rating of care from CPES
- HNA (COSD)
- Personalised Stratified Follow-Up (COSD)
- Number of outpatient slots released
- Number of inpatient stays (prehab)

Figure 51: Ambition, outcomes and measures to improve personalised care

Closing the gap

Individual trusts have secured funding for new roles such as nurses and navigators to provide additional support to patients, and have initiated HNAs. For more detail on specific actions of trusts and providers please see Appendix A. We are implementing the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) programme to support cancer patients in making informed choices about where they want to die and to ensure that, as a system, we support them to do so.

Cancer coaches

SSCA is involved in an innovative project to develop a standardised framework for cancer coaches which will improve the quality and availability of support for our patients. We are

working on this with the University of Portsmouth, who are leading experts in cancer coaching, and the Fountain Centre, who host a significant number of cancer coaches each year. This will be funded in full by Health Education England and is a first step in improving access to psychological support for our patients, which will be continued through setting up a psychological support expert reference group to advise on future work. Please see SSCA's 'Proposal for Cancer Transformation Funding 2019/20' for more details on the project.

Digital support

SSCA has developed recommendations for future digital innovations to facilitate interventions such as holistic needs assessments and to enable greater personalisation. These include implementation of the Macmillan eHNA Tool, developments in the Somerset Cancer Registry, a remote monitoring solution and Personal Health Records.

Sussex Partnership have procured, and are implementing, the "Patient Knows Best" Personal Health Record solution into all providers, with ESHT identified as the initial pilot site. We aim to develop and implement an initial controlled pilot to support both colorectal and prostate cancer patients on supported self-management pathways by the end of 2019/20. This will be supported by a robust remote tracking system and will extend to breast pathways by 2021 as well as other tumour groups by 2023. These learnings will be collected and shared across SSCA to support the collective improvement of personalised care. Personalised care will also be promoted through the pathology hub at ESHT which will extend the use of molecular diagnostics.

SSCA

The Alliance works as an 'Observer Partner' in supporting the EU project 'Inter-Reg I-Know How' to help employees living with cancer remain at, or return to, work. Sussex has also been actively involved in the development and adoption of centralised guidance to support the implementation of personalised care interventions. We will work in collaboration with partners such as Macmillan to develop and test a model for prehabilitation services, and adopt Macmillan's 'Right By You' approach to deliver personalised, holistic support, integrated across multiple settings.

Specialist Commissioning will promote the expansion of Enhanced Supportive Care, to enable patient choice and informed decision making, pump-priming investment in priority cancer providers to achieve this, and taking a leadership role in sharing learning across the South East.

7.2.8. **Workforce**

To diagnose and treat cancer more effectively within Sussex will place a greater demand on diagnostic services, which requires a growth in the local cancer workforce as well as investment in new methods of delivering care to our population.
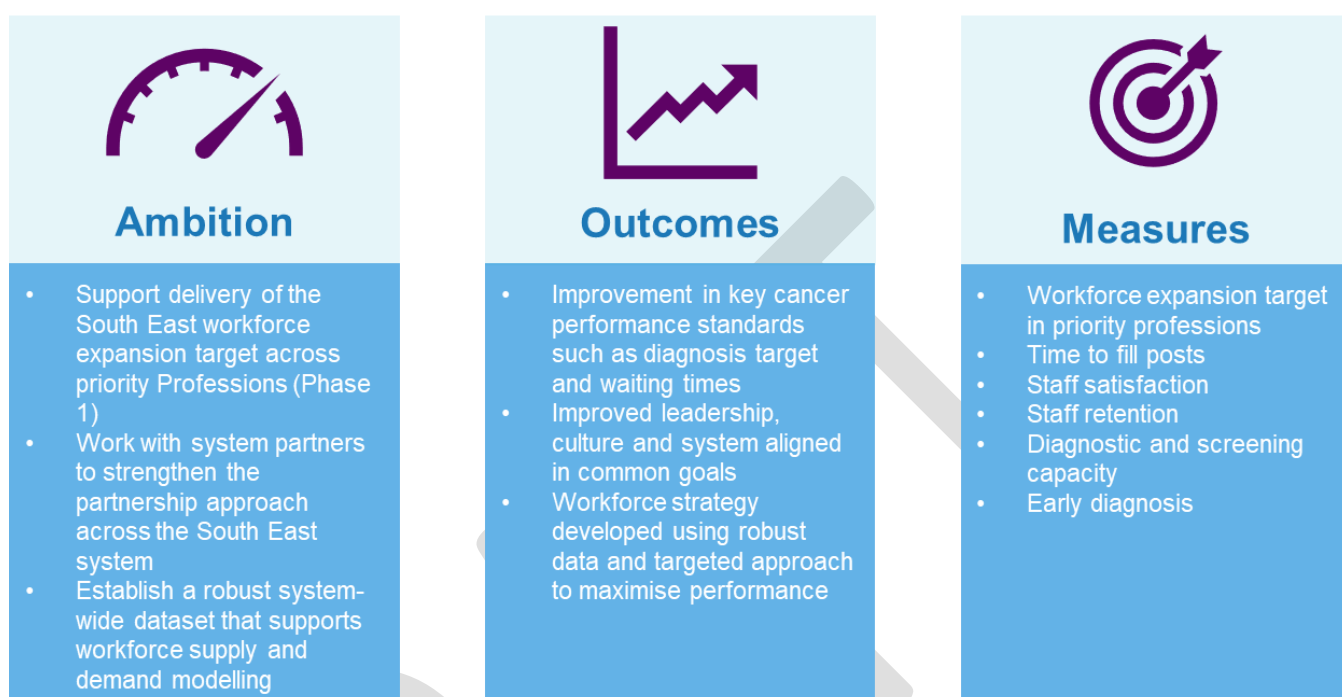
Ambition	Outcomes	Measures
• Support delivery of the South East workforce expansion target across priority Professions (Phase 1) • Work with system partners to strengthen the partnership approach across the South East system • Establish a robust system-wide dataset that supports workforce supply and demand modelling	• Improvement in key cancer performance standards such as diagnosis target and waiting times • Improved leadership, culture and system aligned in common goals • Workforce strategy developed using robust data and targeted approach to maximise performance	• Workforce expansion target in priority professions • Time to fill posts • Staff satisfaction • Staff retention • Diagnostic and screening capacity • Early diagnosis

Figure 52: Ambition, outcomes and measures to improve cancer outcomes through a supported workforce

Closing the gap

The current activity of SSCA to ascertain the baseline workforce position and create specific action plans will be completed in partnership with Health Education England, and provide detailed targets for capacity and capability development to meet our demand trajectories. For more information on Alliance-wide actions with relation to radiographers, endoscopists, histopathologists, mammographers, CNSs, sonographers, screening and primary careworkforce, please see the Surrey and Sussex Cancer Alliance (SSCA) plan.[12]

Sussex are keen for SSCA to also consider oncologists, surgeons and theatre staff in their capacity assessment and to focus upon appropriate skill mixes across trusts. The workforce review will also need to take account of skill mix, role developments, rotation and flexible working across the Partnership, as well as cross-Alliance services such as the Operational Delivery Network and BSUH's position as a radiotherapy centre.

We acknowledge that the success of interventions aimed at improving early diagnosis will mean an increase in 'curative' treatments which, for some pathways, will mean an increase in the demand for surgeons, oncologists, radiotherapists and other staff.

---

[12] See Surrey and Sussex Cancer Alliance, 'System Ambitions 2019-2024', pg 41

Page 97 of 185

7.2.9. Public and Patient Participation

Ambition

- Ensure that all services and improvements are developed and designed in partnership with our patients based upon their lived experience
- Reduce variation and inequalities in the delivery of cancer services across Sussex
- Improve accessibility of cancer services

Outcomes

- PPP strategy in place
- Improved screening uptake in seldom heard groups
- Patient hubs available across the alliance footprint
- A co-designed approach to service improvement becomes BAU

Measures

- Screening uptake
- National patient experience score (aggregate and provider)

Figure 53: Ambition, outcomes and measures to improve public and patient participation

Feedback

The Partnership has undertaken significant patient engagement which drives both the priorities within this plan and the phasing of those priorities. The 2018 Cancer Patient Experience Survey (CPES) scores demonstrated that patients were overall very satisfied with the quality of their care, with ratings between 8.6 and 8.9 out of 10 across all trusts.[13] Areas for improvement were also identified and have contributed to the strategy in the following ways:

- Across three trusts, scores in 2016 were lower than average for support given to patients during treatment by general practice. Therefore, we are running ongoing GP education and ensuring that each patient has an individual care plan which is circulated within primary care.
- In two trusts in 2016, there was room for improvement around Clinical Nurse Specialist (CNS) provision and support, so we are working in collaboration with system partners to ensure that all patients have access to the right expertise through CNS and support workers.
- In 2018, scores were lower than average for length of time spent waiting for a diagnostic test in two trusts, which will be addressed by the introduction of Rapid Diagnostic Services.
- The proportion of patients with whom taking part in cancer research was discussed was also lower than average in two trusts, which highlights the need to further promote rapid uptake and spread of innovation.

---

[13] The 2018 results were only published in September 2019, therefore the previously available 2016 results have contributed to the current strategy and the 2018 results will be used on an ongoing basis.

Communication approach

Screening is one of the key areas of the SSCA strategy that can be locally supported by effective and coordinated communications across Sussex to raise awareness and improve accessibility of screening for bowel, breast and cervical cancers.

Communications activities will be targeted using insights, based on evidence of screening uptake and supporting national campaigns to support improvements and build upon our successes. Tailored communications will be data-driven and targeted to sections of the community who are not taking up their screening opportunities, and to GP surgeries where patients have a low take-up.

All CCGs have taken, and will continue to take, an active part in all the national campaigns:

- **March -** Cervical Screening campaign
- **April -** Bowel Cancer Awareness Month
- **June -** Cervical Screening Awareness Week (Jo's Trust campaign)
- **July -** Be Clear on Cancer campaign
- **October -** Breast Cancer Awareness Month

CCGs will continue to work with local community and voluntary sector groups as well as linking in to events to promote awareness and support people living with cancer. For example:

- Brighton and Hove Albion's community project helps cancer patients get back to fitness and was featured on BBC Match of the Day in 2018
- Switchboard, together with Macmillan, hosted a creative focus group consulting about LGBTQ cancer care to support people living with cancer on the 15th October 2019 for healthcare workers and volunteers

Leaflets and posters	Designed materials will be sourced with relevant messages and disseminated, and made available in a wide range of targeted public locations, this will include within GP surgeries
Media	The media plays a key role in influencing people's opinions and knowledge and, as such, we will utilise this to promote the screening programmes
Website and social media	Cancer screening information will have a presence on CCG websites, and the screening messages will be promoted heavily through CCG social media channels
Existing CCG communications	The screening messages will be promoted through the CCGs' existing communications to staff, members and the public, including the weekly staff and GP practice bulletins and external newsletters
Partners, stakeholders and local employers	The CCG will provide communications materials for partners, stakeholders and local employers to promote the screening messages
Events/groups	We will engage with key audiences at established groups and planned events - meetings, forums and groups - to discuss the key messages and gather feedback from those present
Digital communications channels	We will undertake a number of communications initiatives through digital channels throughout the campaign

Figure 54: Communication materials and channels

Accessibility

Sussex Partnership is fully committed to ensuring that our communication methods are accessible to all members of the community, and will proactively take steps to ensure the

Page 99 of 185

core messages relating to cancer are promoted in accessible formats, including British Sign Language and Easy Read format. We will also inform organisations who can provide support for vulnerable patients. These will include:

- Sussex Interpreting Service
- Speak Out (for adults with learning disabilities)
- Carers Centre
- LGBT Switchboard
- Age UK

For more detail on metrics, priorities and cancer planning, please see the Surrey and Sussex Cancer Alliance Long Term Plans for 2019-2024.

Working in partnership across Sussex

7.3. Improving mental health outcomes

7.3.1. Current state and challenges

In 2017, what was previously the Sussex and East Surrey STP developed its case for change which laid out how the health and care system in Sussex could better help people with mental health conditions to lead more fulfilled lives. We knew that:

- Severe mental illness affected 25,000 individuals in Sussex, with many more affected by common mental health problems including anxiety and depression
- Local mental health services were stretched and demand on services was increasing significantly year on year
- Crisis care provision for people with mental health problems in Sussex was failing to meet people's needs
- Individuals with severe mental illness in Sussex died between 15 and 20 years younger than those without
- Dementia prevalence was 25% higher than nationally reported figures
- Three quarters of first episodes of mental ill-health occurred in young people and yet mental health services for children and young people were under particular demand pressures
- We would not solve the problems facing mental health services unless we undertook a programme of major transformational change.

Our current mental health transformation plans have been developed through extensive public engagement with service users, carers, partner agencies, providers and commissioners. They began with the Sussex Partnership NHS Foundation Trust Clinical Strategy (March 2017), which was built upon through an independent review of mental health provision resulting in the STP Mental Health Case for Change (November 2017), and then further developed and refined to produce the STP mental health transformation programme. More recently, we have incorporated the priorities of the Long Term Plan into our local transformation programme which has resulted in the development of the following workstreams:

- Perinatal Mental Health
- Children and Young People (CYP) Mental Health – including CYP Crisis
- Adult Common Mental Illnesses (IAPT)
- Adult Severe Mental Illnesses (SMI) Community Care
- Adult Liaison Mental Health
- Adult Crisis Alternatives
- Ambulance mental health provision (all ages)
- Therapeutic Acute Mental Health Inpatient Care
- Suicide Reduction and Bereavement Support
- Rough Sleeping Mental Health Support

Within Sussex, we are well placed to deliver upon all of these ambitions for mental health as a result of having:

- An agreed integrated strategic approach to mental health transformation for Sussex that has been developed through robust partnership work between commissioners, local mental health providers and local service users, carers and their families. These

strategic plans are fully aligned with the LTP priorities for mental health.

- An agreed delivery approach within the Partnership that enables us to successfully manage major mental health transformation work through strong integrated partnership arrangements between commissioners and providers.
- A well-established leadership and governance framework for mental health across the Sussex Partnership which has been in place since early 2018, led by the Partnership's Mental Health Programme Board and supported by a Mental Health Delivery Group and Finance Group.
- Identified mental health as a priority area for our Partnership which is enabling us to challenge systems and processes across physical, social and mental health settings and more effectively address the physical / mental health integration agenda.
- Good strategic partnerships in place across sectors and systems with clear plans to develop these further, for example through the development of a joint mental health/prevention strategy in 2020/21.

7.3.2. Five-year vision

By 2025, all people with mental health problems in Sussex will have access to high quality, evidenced-based care and treatment delivered by integrated statutory, local authority and third sector services that are accessible and well connected with the wider community, and that intervene as early as possible in someone's life journey to prevent mental ill health.

Our mission

We will work together as an Integrated Care System, bringing together patient, statutory, third sector and local authority expertise, to design, develop, commission and oversee high quality, innovative and integrated care and treatment pathways for people with mental health problems. We have also set clear trajectories to meet the seven key activity metrics for mental health relating to Out of Area Placements, SMI health checks, perinatal mental health, meeting the Core 24 standard, EIP services, and 24/7 crisis provision. For more information, please see activity modelling in the Strategic Planning Tool in addition to the greater detail provided in Appendix E.

Our road map

We have described our detailed plans for the future of mental health services in Sussex in the attached commitments planner, Appendix E. This lays out our current state, five year objectives, actions to meet these objectives, key performance indicators, and interdependencies for each of our workstreams. These plans will be delivered in line with our roadmap for Sussex which lays out objectives and current progress.
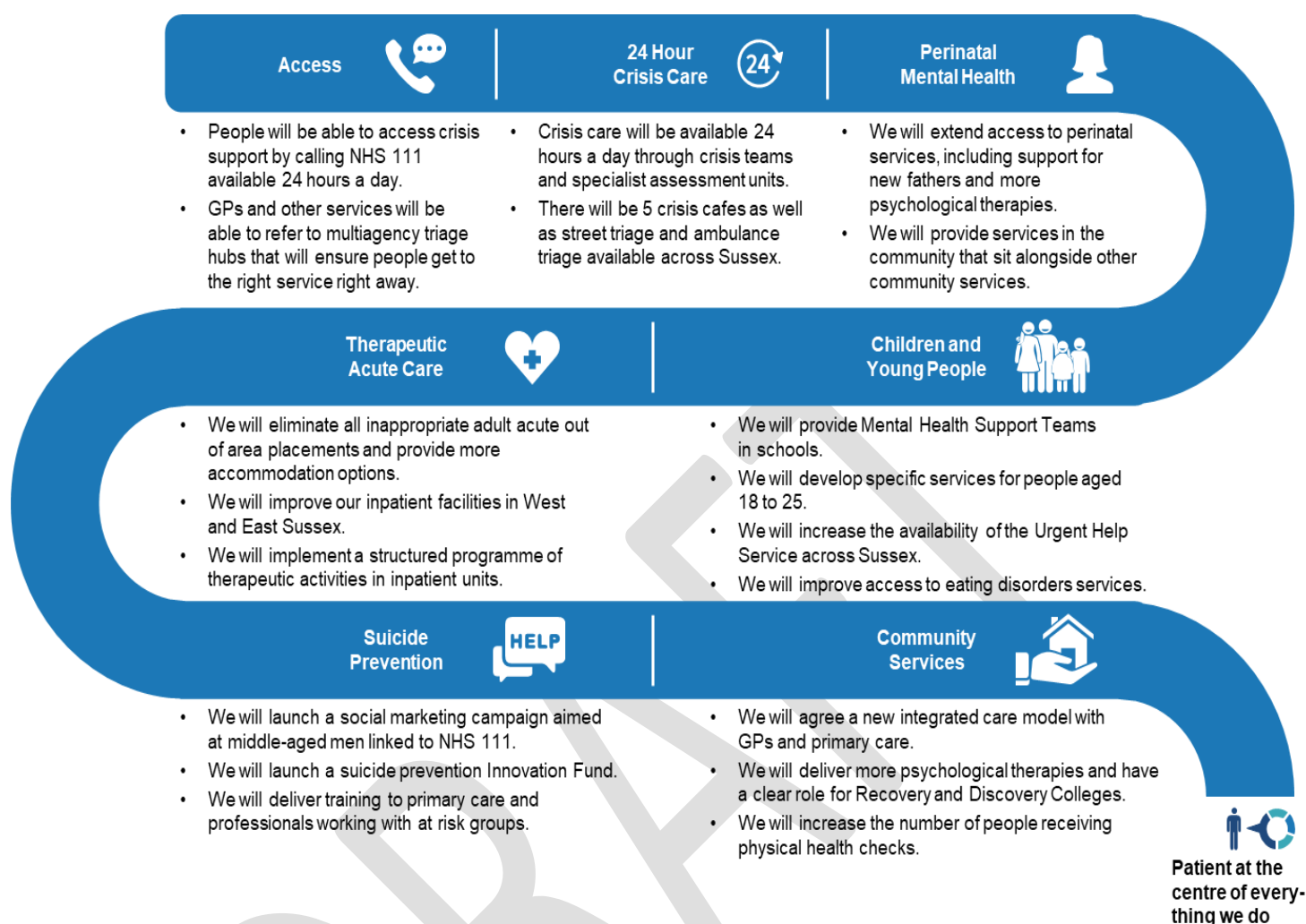
Access

- People will be able to access crisis support by calling NHS 111 available 24 hours a day.
- GPs and other services will be able to refer to multiagency triage hubs that will ensure people get to the right service right away.

24 Hour Crisis Care

- Crisis care will be available 24 hours a day through crisis teams and specialist assessment units.
- There will be 5 crisis cafes as well as street triage and ambulance triage available across Sussex.

Perinatal Mental Health

- We will extend access to perinatal services, including support for new fathers and more psychological therapies.
- We will provide services in the community that sit alongside other community services.

Therapeutic Acute Care

- We will eliminate all inappropriate adult acute out of area placements and provide more accommodation options.
- We will improve our inpatient facilities in West and East Sussex.
- We will implement a structured programme of therapeutic activities in inpatient units.

Children and Young People

- We will provide Mental Health Support Teams in schools.
- We will develop specific services for people aged 18 to 25.
- We will increase the availability of the Urgent Help Service across Sussex.
- We will improve access to eating disorders services.

Suicide Prevention

- We will launch a social marketing campaign aimed at middle-aged men linked to NHS 111.
- We will launch a suicide prevention Innovation Fund.
- We will deliver training to primary care and professionals working with at risk groups.

Community Services

- We will agree a new integrated care model with GPs and primary care.
- We will deliver more psychological therapies and have a clear role for Recovery and Discovery Colleges.
- We will increase the number of people receiving physical health checks.

Patient at the centre of everything we do

Figure 55: Our mental health delivery roadmap

7.3.3. Key priorities to deliver

- **Clear and detailed transformation plans for mental health services that are owned by the whole healthcare system**. We believe we already have these in place (detailed in the above section).
- **Robust leadership and governance that adapts to the changing healthcare environment**

Our current leadership and governance structures are overseen by two executive sponsors, the CEO of our Provider Trust and the Deputy CEO of our seven clinical commissioning groups, who chair the Partnership Mental Health Programme Board. A broad range of stakeholders from across our system sit on our Programme Board and it meets quarterly to assure the delivery of our priorities and the identification and mitigation of key risks. Our delivery and governance structures are supported by our Delivery Group (chaired jointly by our two SROs) and Mental Health Finance Group (chaired jointly by our provider FD and Commissioner FD). Robust governance and risk management systems are in place.

Page 103 of 185

Moving forwards, we will need to further develop these governance and leadership structures to reflect the needs of the Sussex Integrated Care System (ICS) – and the requirements and reporting arrangements of CCGs, PCNs, provider trusts, and the third sector, that make up the ICS.

1. Financial planning

We welcome the Long Term Plan (LTP) commitment to grow investment in mental health services faster than the overall NHS budget. Our financial plan for mental health assumes an increase of £50.5m over the next five years, plus an estimate of fair shares additional funding of £18.8m. Further transformational funding has not been included at this stage.

In terms of financial governance, we already have a well-established Mental Health Finance Group in place that is jointly chaired by our provider and commissioner Finance Directors. This group will ensure that there is full oversight of the investment in mental health and that the investment is used to support the delivery of the commitments in the Five Year Forward View for Mental Health and the Long Term Plan.

2. High quality workforce plans

We are committed to delivering our transformation plans at pace and scale. Yet, despite timely, detailed and high quality business plans for our workstreams, the key underlying risk to delivery is the availability of our workforce. We must balance the staffing requirements for new services and new roles with the need to avoid overly disrupting operational activity within existing services. To mitigate this risk, we have set up a dedicated workforce group, chaired by senior provider and commissioner leads with input from the Sussex Partnership Workforce Director and HEE mental health lead.

We have undertaken detailed workforce modelling for 2019/20 to help forecast workforce and recruitment pressures across our workstreams. We have also secured additional funding for HR and recruitment support and implemented several new roles into the mental health workforce, including peer workers, graduate mental health workers, non-medical prescribers, nursing associates, physician associates and non-medical Responsible Clinicians.

In anticipation of the need to recruit significant numbers of new staff, work is under way to develop an overarching workforce plan that identifies potential recruitment streams. As part of this, the trust has been actively developing a range of new roles, including Nurse Associates, Peer Support Workers, Graduate Mental Health Practitioners and Physician Associates, in recognition that the level of workforce expansion will only be achieved through thinking more broadly about the range of skills and experience needed to deliver services in the future.

3. Partnerships and place

Whilst we have strong principles around partnership working already embedded in the programme, we are ambitious with our plans to further develop and strengthen the role of housing and third sector partners. We have developed a task and finish group (Sector Connector) to support a diverse sector to influence change and engage more fully in the work of our mental health programme. Proposals are being developed for sector representation on the Programme Board, the development of mental health forums for the three places, and an overarching mental health Partnership Board across Sussex.

We are fortunate to have some well-established third sector partners providing a range of

Page 104 of 185

services across Sussex, for example, Southdown Housing Association provides social prescribing services across East Sussex, working closely with Primary Care Networks. The West Sussex Pathfinder Service hosted by Worthing Mind also offers:

- Access to a clinical service provided by nurses and occupational therapists from Sussex Partnership NHS Foundation Trust who work alongside other Pathfinder agencies
- Support to successfully discharge people from Sussex Partnership teams (Step Down) and to link them to the wider Pathfinder Alliance
- Proactive preventative support and links to Sussex Partnership teams if required (Step Up) for people accessing Pathfinder Services
- Improved links for people between other critical partners (Step Across), such as 'Time to Talk'.

Developing partnerships at place level across health and social care is critical to the success of this transformational programme of work. Embedding the mental health priorities within mainstream health and social care provision is key to delivering improved outcomes for people within our communities who need mental health support. Workstreams such as Community, IAPTS, Dementia and Suicide Prevention have a strong place-based focus and more information can be found on our programmes of work and the role of the places within Appendices A,B,C and D. As part of our programme review, we are working through our governance and programme function and structure to strengthen support to places and PCNs and to articulate clearly the role of Sussex Health and Care in supporting the delivery of the plans.

Considering the different population and demographic needs across our diverse Partnership is necessary to enable specific local needs to be addressed, whether this is supporting rough sleepers in Brighton & Hove, addressing the mental health needs of an ageing community in East Sussex where 26% of the population is over 65, or supporting the reduction in hospital admissions for self-harm in young people in West Sussex. We are committed to using our data to develop local solutions to specific local need and tailoring our Sussex-wide policies for maximum impact.

4. Consolidating capacity and capability

Through our transformation workstream plans, we are ensuring that we have access to dedicated finance and data analytics support to strengthen our ability to demonstrate Quality Improvement across the programme in reducing cost, improving health outcomes, and improving our service user experience.

Additionally, we have established a Data and Analytics Task and Finish Group to develop further recommendations for our Programme Board. Our portfolio of work also includes ambitious use of digital technology, and intrinsic to this is Sussex Partnership Digital Exemplar status. Robust estates plans will also be key to the successful transformation of our community, patient flow and rehabilitation workstreams, including the development of more supported housing for our service users.

5. Prevention

Across Sussex, we are committed to developing a prevention strategy for mental health. The approach will build upon the SPFT prevention strategy and the broad range of prevention work that is already in place across Sussex. The mental health prevention strategy is being

co-produced with public health colleagues and will be reflective of the broader Partnership prevention strategy, drawing strong links between mental and physical health. By working closely with the Prevention Board and our public health colleagues, we are highlighting the importance of place-based working, and developing local plans that are based upon the needs of the local population. For more information on mental health prevention please see Appendix A and section 6 on Prevention.

6. Provider Collaboratives

Locally, we have worked with Specialised Commissioning to engage with the national Provider Collaborative process which has sought to devolve specialist budgets to local providers. This has been through a shadow New Care Models phase since 2017 with adult secure services in Kent, Surrey and Sussex, and with CAMHS services in 'Wessex' (Hampshire, Portsmouth, Southampton, Isle of Wight and Dorset).

This has proved a successful service model and development process which has brought together a wide range of partner organisations, designed new care pathways, introduced efficient mechanisms, and controlled expenditure for specialist placements. This has been achieved by focusing on the needs of the individuals receiving services through developing intensive community services and bringing people nearer to their homes.

Together with Specialist Commissioning, we will:

- Ensure that Case Managers are in place to manage the Long Term Segregation and Seclusion quality improvements
- Reinvest savings from Adult Secure Services NCM pilots into Forensic Outreach Liaison Services
- Take commissioning responsibility for patients requiring Adult Secure Care, CAMHS Tier 4 and Adult Eating Disorder Services
- Align the ambitions of the CAMHS Tier 4 Bed Capacity Plan and support delivery of the South East share of the National Accelerated Bed Plan with local ICS/STP MH plans for children and young people.

The Sussex Partnership now has agreement in principle, pending submission of final business cases, to be the Lead Provider for the Provider Collaboratives across the STP for Adult Secure Services, CAMHS Tier 4, and adult eating disorders. The development process will fit with the three national streams of work and be banded as follows:

- Kent, Surrey and Sussex Adult Secures and Wessex CAMHS: "Fast track" – with approval planned for December 2019 and contracts signed for a 1 April 2020 commencement
- Sussex and Surrey CAMHS: "Development" – with approval planned for 2020 and commencement on 1 October 2020
- Adult Eating Disorders for Sussex and Kent: "Further development" – a longer timeline fitting in with further calls for applications in April 2020.

The total value of the contracts when fully operational in 2021/22 will be £150m per annum. This budget will form the lead provider commissioning budget for services across Kent, Surrey and Sussex for Forensic and Eating Disorder services, and for CAMHS in patient services across Sussex, Kent, Hampshire, Southampton, Portsmouth, the Isle of Wight and Dorset. The table below indicates the split of this between specialties:

Page 106 of 185

	No. inpatients	Budget (£'000s)	Infrastructure (£'000s)	Total (£'000s)
Total Forensic Services to transfer from NHSE	408	92,093	600	92,693
Total CAMHS services to transfer from NHSE	208	46,119	500	46,619
KSS Eating Disorders			1,218	1,218
Infrastructure costs transfer estimate	30	10,038	-	10,038
Total	646	148,250	2,318	150,568

Figure 56: Specialty split for provider collaboratives

7.3.4. Public engagement

In developing the case for change which underpins our current mental health transformation programme, we held two large scale workshops with service users, NHS and local authority professionals, health and care commissioners, and providers. We interviewed 60 system leaders, GPs and representatives of service users. We also surveyed over 400 service users and carers using an online survey and sought views from clinicians and the voluntary sector. In addition, we analysed data provided by local authorities, commissioners and providers of mental health services, and others.

Service user involvement related to mental health within Sussex has been, and continues to be, comprehensive. There is a patient lead who attends the Delivery and Programme Boards and co-chairs the Expert Reference Group, also attended by the CEO of Healthwatch. Our role is to work together to ensure that the groups are continuously thinking about the patient perspective, representing information gathered through the workstreams, and engaging at different levels.

The workstreams develop engagement events across Sussex to provide feedback and collaboration opportunities for patient and carer input into finalising and agreeing papers and documents. The Expert Reference Group provides a pragmatic view of information coming from NHSE and ensures that the groups are considering local issues alongside national requests. Their role is to influence the volume of engagement that workstreams have with public, patients and carers at a Sussex-wide and place level.

7.3.5. Digital and estates interdependencies

The Mental Health Programme requires digital solutions and innovations to help us achieve the ambitions set out in our plans. We are fortunate that Sussex Partnership Trust (SPFT), our main mental health provider, is a digital exemplar site. For all our workstreams, the use of digital solutions to provide remote consultations, Apps to provide a proactive, self-care approach, and the roll-out and adoption of online platforms, have been identified as important. Capturing and sharing data is a priority and, with the expectation that we will work with a wide and diverse range of providers, we must ensure that data can be captured and information shared across sectors and settings. The cost of our digital transformation

programme will be substantial, not least due to the cost of equipment and telephones for a significant increase in workforce.

The estates requirements to enable us to deliver the Long Term Plan are substantial. With an increase of over 600 staff over a five year period, new models for providing work spaces and hubs for staff will be a priority. More joined-up working will lead to teams being co-located. We have some stretching targets for remodelling community support and providing crisis support for the people of Sussex, and this will require new facilities with crisis cafes being embedded and located within local communities.

We will need significant investment in the community estate to support both increased staffing and closer integrated working with all STP partners. This will include hubs for specialist MH teams that can accommodate the staffing increase and support joint working across teams and organisations. We also need space in primary care services to deliver clinical services and allow for joint working. For more information on the Sussex estates priorities, please see the estates section, 9.2.

We have also identified the need for capital investment of around £70m for mental health inpatient services in East Sussex to ensure that they are fit for purpose and able to flex to future service developments. This will enable us to eliminate mixed sex accommodation, remove dormitories, and increase therapeutic activity with the aim of reducing length of stay.

7.4. Delivering further progress on care quality and outcomes

7.4.1. Maternity and neonatal services

Governance and context

The Sussex Local Maternity System (LMS) formally comes into being on 1st April 2020, developing from the Sussex and East Surrey LMS in response to the changes in STP Boundaries agreed in 2019.

The LMS is transforming local services to achieve the Better Births and Long Term Plan recommendations for maternity services in a way that meets our population's needs, reduces gaps in health inequalities, and improves outcomes.

We are a partnership of local organisations:

- 3 Sussex trusts (ESHT, BSUH and WSHFT) who deliver maternity services
- 1 Surrey trust (Surrey and Sussex) and 1 Kent trust (Maidstone and Tunbridge Wells) who deliver maternity services to Sussex residents from buildings in Sussex
- 3 local authorities including Public Health
- 7 Clinical Commissioning Groups
- 5 Maternity Voices Partnerships (East Sussex, Brighton & Hove, Mid Sussex, SaSH and Western Sussex) representing service users and supporting co-design
- Clinical Networks including the Neonatal Network and the Perinatal Mental Health Networks
- 2 NHS trusts who provide the Healthy Child Services in Sussex

Sussex has a fully approved plan for maternity transformation, developed through significant engagement, which is fully endorsed by the Sussex Health and Care Partnership, the CCG Governing Bodies, and NHS trusts. The LMS Plan describes how we will meet our population's physical, mental and psycho-social needs from maternity services, and the opportunities that exist for us to improve maternity service safety, outcomes and personalisation.

Vision

The vision for maternity services in Sussex, as set out in the LMS Plan, to be safer, kinder, more personalised with real choice has been strengthened with the publication of the Long Term Plan (LTP). The LTP asks Local Maternity Systems to extend the scope of their improvements with a particular focus on addressing health inequalities, improving the post-natal pathway, supporting neonatal service improvements and extending the support available to those with perinatal mental health needs, recognising that the impact can last longer than one year after birth.

We will deliver these changes through close partnership working and integration of services around service users. We will recognise people's differences and accommodate these, as far as is possible, to deliver safer, kinder and more personalised maternity care.

Broadly, whilst the overall birth rate in Sussex is not predicted to change, we recognise there is change more locally within some areas in Sussex. By successfully delivering the LMS Plan we will, as a Health and Care Partnership, achieve better value for the £109 million we

Page 109 of 185

spend each year on maternity services.

Figure 57: LMS Vision

There are a number of key priorities across our LMS which are briefly highlighted below. For more information on all areas of the maternity strategy, please see additional documents including the Sussex and East Surrey LMS Transformation Plan and LMS Smart Action Plan 2019.

Perinatal health

Whilst pregnancy is not an illness, the antenatal, birth and postnatal periods can sometimes be far from straightforward, requiring robust management and coordination of care. The LMS Plan focuses on partnering more closely with service users and understanding their personal needs. There are a number of factors which can influence the delivery of maternity care, some of which are lifestyle choices. Optimising a healthy weight, stopping smoking, eating well and looking after your mental health and wellbeing before, during and after pregnancy will positively support mothers and babies.

Smoking rates are variable across the LMS in different areas and within different population groups within Sussex. We are working in partnership with our population to support smoking cessation by training our midwives to provide advice and refer patients for further support. For more information on smoking cessation, please see section 6 on Prevention.

People's wellbeing and mental health needs vary throughout their lives and particularly during pregnancy. Our maternity transformation programme focuses on enabling staff to work with women to identify their needs and any changes in these needs throughout pregnancy, birth and after they have given birth. To achieve this, we are working to improve perinatal mental health knowledge and skills amongst our maternity and neonatal workforce, as well as addressing the gaps we have identified in the support available.

Safety

Safety is a key concern for everyone. The LMS has a very specific and important role, being a partnership of organisations, in ensuring our maternity services are working to the latest safety standards, identifying where there is variation in outcomes, tackling this collectively and sharing learning across our trusts. Working together on common problems, the LMS can pool its clinical, service user and professional expertise to address common challenges.

Personalised care

Being supported to make decisions and express choice throughout the maternity journey is key in building trusting relationships between health professionals and service users, and the development of personalised care plans enables this to happen. In addition, the Continuity of Carer model of midwifery care continues to develop, with the LMS aiming to ensure that at least 51% of service users receive this model of care by March 2021. Targeted Continuity of Carer will be available to 75% BAME, deprived and vulnerable groups within Sussex by March 2024 to address health inequalities for these groups. All of this work significantly impacts our midwifery workforce, and the LMS is leading the partnership work to support our midwifery teams to deliver Continuity of Carer in a way that both supports service users and ensures midwifery wellbeing. Our Heads of Midwifery are actively listening to our service users, working with our Maternity Voices Partnerships, service user representatives and their teams to develop innovative models which will work for all.

Choice of place of birth

As well as providing care that is more personalised, we are working with system partners to increase births in midwifery settings, as the national target is to ensure 100% of women booking with a trust providing maternity services can choose from three types of place of birth: home birth, midwifery-led bedded service/unit, and obstetric led bedded service/unit, from their provider. Currently, Brighton & Sussex University Hospitals does not provide service users booking with their maternity service a midwifery-led bedded service. This means that currently in Sussex only 67% of maternity service users have three choices of place of birth. There is potential for the MLU to be co-located with one of the two Consultant-led units in order to provide the choice of three types of place of birth to choose from when they book and throughout their antenatal maternity care. Services are being reviewed across Sussex to put forward proposals to address this issue.

Public engagement

The LMS ensures that our improvements are rooted in co-design through engaging with service users through surveys and Maternity Voices Partnership (MVP) representatives. Sussex funds five MVPs across the LMS geography, ensuring there are service user representatives as partners at all meetings, decision making forums and workstreams. Each of our MVPs has a programme of work to connect with the population they represent and ensure they can act as their voice, to work with their local trust to ensure experience informs improvements, and to bring this to the LMS-wide work.

Digital interdependencies

The LMS will continue to work closely with NHS Digital to improve digital maternity services in line with the Better Births recommendations and the Long Term Plan. The interoperability of both internal and external hospital systems is a key improvement that will enable clear communication between healthcare professionals, improving safety and reducing risk. The implementation of new updated maternity systems will improve data quality, which in turn will enable more robust reporting, better targeting and monitoring of specific groups, and support the reduction of health inequalities. For more detail please see the digital workplan for maternity.

As a system, we are committed to providing a strong start in life for our children and young people. Our strategy is one for our whole population which should support the journey from birth to old age. We are addressing a number of commitments for children and young people at place level, where these commitments involve local integration of services and co-production with children, young people, families and carers. Place-based development of age-appropriate integrated care is the optimum method for integrating physical and mental health services, enabling joint working between primary, community and acute services, and supporting the transition towards adult services.

We encompass wide variation in outcomes for children, including in relation to child poverty, where rates range from 7.3% in Horsham & Mid Sussex to 22.7% in Hastings & Rother. Obesity is also an issue locally, which reflects the national picture, as 7.8% of reception pupils and 15% of year 6 pupils were measured as obese across the Partnership, with higher proportions within deprived areas. Brighton & Hove also faces particular challenges, with the highest percentage of 15 year olds who smoke or have tried cannabis in England and the 3rd highest percentage of 15 year olds who drink weekly.

Integrated care, enabling primary, community and acute services

Our vision is to provide more responsive support for children and young people when they experience poor mental health or are in crisis so that they can access services when, where and how they choose, embracing digital and social media.

An important facet of integrated care is working together to deliver physical and mental health services. Due to increases in funding for children and young people's mental health, there is more focus on self-harm and the A&E pathway to keep children and young people healthy through building resilience. For example, the Alex Children's Hospital has developed a multidisciplinary approach to children and families, which is expanding to include the current team for Chronic Fatigue Syndrome/ ME in order to build up a more robust and inclusive service. Similarly, West Sussex's 'Find It Out Plus' programme is an integrated hub approach to emotional wellbeing and mental health for young people.

A key component of better integrated care for children and young people is close working with the local authority to support integration of health, social care and education needs. For example, Brighton & Hove is moving towards joint delivery and joint commissioning of children's community services with the local authority. East Sussex is looking to integrate disability pathways for children and young people across education, health and social care needs.

We are using data to target interventions at vulnerable groups which includes considering LGBT children and young carers. Through our places, we are also engaging a wide range of partners in primary and community settings to collaborate around a whole schools approach to build resilience and improve health and wellbeing outcomes for all pupils.

To be rolled-out at a Sussex level, NHS England will develop a national service specification for offering a digital child health record (e-red book) to help parents record information about their child's health. Local public health commissioners will support its implementation at a place level in conjunction with the local Child Health Information Services.

Page 113 of 185

Our plans for learning difficulties and autism are also closely related to our provision of children and young people's services in Sussex – see section 6.5.3 for full detail.

More detail on the integration of children and young people's services can be found for each place in the Appendices.

Supporting transition to adult services

A more joined-up multidisciplinary approach as our children and young people transition to adult services is essential for increasing independence.

As we develop our PCN and primary care offer, there is an opportunity to enhance the support provided to young people outside of the current acute focus, particularly for those with complex health and care needs, as they transition to adult services. We will build upon our strong foundation in children and young people's mental health to develop a more integrated approach in this area.

We will also look to provide a holistic offer for our children and young people as they transition to adult services, including training support to colleges and work placements.

More detail on the transition to adult services can be found for each place in the Appendices.

7.4.3. Improving care for people with learning difficulties and autism

Learning difficulties (LD) and autism are a strategic priority for Sussex. We have a robust recovery plan which has been developed with partner agencies, with a significant level of executive leadership up to and including CEO level.

Major investment has been obtained in order not only to achieve the targets for people with LD and autism receiving inpatient care, but also to make long term and sustainable improvements to people's lives.

The Sussex Transforming Care Partnership (TCP) has also sourced additional resource to provide both capacity and expertise in improving systems, governance and oversight of the programme.

The Sussex TCP works across service providers, clinical commissioning groups and local authorities to improve services for people with a learning disability, autism, or both. We aim to make a real difference to the lives of local people, their families and carers, making community services better so that people with these conditions can live near their family and friends, and making sure that the right staff with the right skills are supporting them to do this.

Current state and challenges

Sussex TCP has made significant progress but also faces many challenges. We consistently have one of the highest inpatient populations within the Transforming Care Programme in the South East and a comparatively high proportion of people diagnosed with autism over the last year relative to the South East as a whole.

Page 114 of 185

We know that training and awareness around autism has an impact on quality of care and outcomes for people, and we are supporting training with providers to make improvements in this area.

The Partnership has a relatively low usage of Locked Rehab beds in comparison to other TCPs in the South East, however we have seen a slow increase in average length of stay for all patients during their current placement. This has occurred while most other TCPs have experienced a decrease, causing Sussex to move from having the second shortest average length of stay to having the fourth highest in May 2019.

Sussex Steering Group are performing poorly on the LeDeR review relative to the South East. Of 179 notifications of death, only 23 have led to completed reviews, and within the Steering Group, three of the CCGs have reviewed less than 10% of deaths. All CCGs have failed to reach the total performance level of the South East.

We recognise the implications of LD and autism in terms of health outcomes, including a shorter average lifespan, and very significant health inequalities, and are committed to improving this through better analysis of mortality through the LeDeR programme, increasing the numbers of annual health checks in primary care, and developing more supportive community services.

However, Sussex also has many areas of strength, for example we have one of the highest Care and Treatment Review (CTR) uptake rates across the South East for adult inpatients, with 68% of adults having had a recent valid CTR.

Delivery priorities

Our delivery priorities for the next five years are as follows.

Involving people with lived experience and their families in checking the quality of care, support and treatment

We are committed to involving people with lived experience and their families in checking the quality of care, support and treatment and ensuring that all local services, including primary care and mental health, make reasonable adjustments for people with learning disabilities, autism, or both, when they need them.

We will continue the lived experience engagement project for those who have experienced inpatient care, including:

- Ongoing engagement with LD Partnership Boards and Speak Out advocacy group in Brighton & Hove
- Continued support for the Positive Behaviour Support network, with local patients and carers feeding experiences into meetings via case studies and films
- Involving people and their carers in capital development consultations
- Supporting the Children and Young People's TCP Working Group, which meets monthly and has parent representation
- Workforce planning and development which is key to making sustainable improvements in care, and as well as the autism training mentioned above. We are supporting providers to look at all options around recruitment and retention of staff, including apprenticeships.

Page 115 of 185

Achieving the nationally set target for reduction in inpatient usage and beds

We have a collective inpatient number of 91 against a target of 50, and we aim to reduce this to at most 73 by March 2020 and 50 by March 2021. We will achieve this by further developing the Dynamic Support Register, increasing the frequency and effectiveness of CTRs, and increasing the number of case managers to deliver timely discharges and improved governance through monthly multi-agency discharge planning meeting.

We have developed a robust recovery plan to achieve the target for people receiving inpatient care, and improvements have already been made with 13 discharges already planned and on track between now and the end of March. Further discharges are actively being planned. Joint funding from NHSE and the CCG have enabled significant investment to improve skills and capacity to achieve this.

We have a dedicated housing team who are focused solely on breaking the log-jam of obtaining housing and care support by developing the provider landscape, solving problems and managing relationships across statutory and third sector organisations. We have also secured high level LGA support for two days a week to help us work across the system around housing and the local social care market, and to increase the effectiveness of working practices with colleagues in local authorities.

We are also committed to ensuring the principal aims of the TCP programme are achieved and that people who are unnecessarily in inpatient settings are supported in the community. We have reviewed the list to ensure we focus on the most appropriate individuals for discharge, while having oversight of all. We aim to reduce reliance on inpatient care for people with a learning disability and/or autism, with our targets set out in further detail in the Strategic Planning tool.

Monthly face-to-face discharge planning meetings are held in all three local authority areas and the proactive multi agency input is having an impact in pushing forward the often complex discharge process.

We have strengthened our governance arrangements and have an assurance process in place with Anne Eden and Adam Doyle providing executive oversight. We have made significant progress on delivery planning, with Moorhouse providing project support, increased provider engagement, and a workshop with providers planned for October 2019.

Achieving the target for physical health checks for at least 75% of people aged over 14 with a learning disability and/or autism

The delivery of an effective dynamic support register will provide proactive management of escalation and the ability to respond quickly and effectively in cases where adults, children or young people in the community are at risk of being admitted to inpatient settings. We will work with Primary Care Networks, enlisting the cooperation of Beacon Sussex GP practices (currently at or above 65%) to work in partnership with lower performing practices, with reimbursement, via reallocation of the DES payment. We will target a 20% increase based on current performance by March 2020, and a 50% increase by March 2021, aiming to achieve the national target by 2023. Further information on our targets is set out in the Strategic Planning tool.

The STOMP and STAMP initiatives are being led by our LD commissioner and are making improvements to prescribing practices in the care of people with LD and/or autism in

Page 116 of 185

partnership with prescribing and primary care clinicians.

We will continue to deliver the local LeDeR programme and increase the number of Learning Disabilities Mortality Reviews, increase the current pool of reviewers and ensure dissemination of learning and embedding good practice via steering group and mortality meetings. Additional administrative support will be provided in order to source and process records.

Proactive case management

The TCP is recruiting to some key roles which will see team capacity enhanced by additional case managers, support for both care and treatment reviews, and establishing the dynamic support register. This will provide the capacity to not only progress current discharges and delivery of community supported living but also identify risk and more effectively support people already in the community.

Children and young people

The rate of ASD diagnosis is increasing and the challenges are significant. The TCP is working with lead children's, LD and mental health commissioners to improve the service we offer to children and young people, particularly in relation to transfers from children's to adult services, SEND and education health and care plans, children in residential special schools who have a higher risk of inpatient episodes, and improving education and employment opportunities.

7.4.4. **Reducing unwarranted clinical variation**

Programme structure

As identified by our Population Health Check, we have pockets of significant unwarranted clinical variation across our footprint. Sussex Health and Care Partnership established a system-wide Unwarranted Clinical Variation (UCV) Programme, with a commitment to work collaboratively to co-design evidence-based pathways and deliver value across the footprint.

The UCV Programme Team have been working in alignment with the ambitions set out in the Long Term Plan, and with multi-stakeholders across the Sussex geography, to identify opportunities to address the unwarranted clinical variation and deliver effective, high quality patient-centred care, resulting in:

- Improved Quality of Care
- Improves Health Outcomes
- Improved Shared Decision Making between Patients and Clinicians
- Improved Value, achievement of best possible outcomes for individual patients and for the public within available resources.

Based on the findings from our *Right Care* and *Getting It Right First Time* benchmarking data, and in line with the commitments in the Long Term Plan, we are currently targeting three priority areas over the next five years: Cardiovascular, Musculoskeletal and Falls. These current priorities are based upon our benchmarking data and address areas where variation is widest across Sussex. However, we have future ambitions to expand the scope of this programme over the next five years, including to cover more CVD commitments, not

Page 117 of 185

just those where our variation is currently widest. As inequalities are a significant focus of our Sussex strategy, all workstreams are expected to address inequalities in access, treatment and experience, and information related to inequalities can be found within individual clinical sections of the strategy, e.g cancer and mental health.

Cardiovascular services

Challenges

- A higher rate of elective angiography and stenting for stable angina in Sussex, despite a lower estimated prevalence of angina
- A higher rate of diabetic foot amputations than the national average
- Variability in the identification and management of Atrial Fibrillation and stroke prevention
- Referral, uptake and completion rates for cardiac rehabilitation lower than the 70% target.

Future vision

By 2023/24 we will have:

- Reduced the number of people to have suffered from stroke through the delivery of proactive diagnosis and optimisation of anticoagulation treatment of Atrial Fibrillation, which will be widely available across Sussex Health and Care Partnership's population.
- Increased the number of people who are conservatively managed for their stable angina through establishing NICE care pathways that deliver CT coronary angiograms where clinically appropriate, and non-invasive functional testing by means of investigation first line where stable angina cannot be excluded by clinical examination alone. This will result in a reduction of third line invasive angiograms, as well as elective stenting of coronary arteries for treatment of stable angin,a as NICE recommended medical management first line, with the exception of a small high risk group.
- Established diagnostic pathways for stable angina that deliver CT coronary angiograms and, if required, non-invasive functional testing, to reduce invasive elective angiography and stenting according to NICE guidance.
- Streamlined access to echocardiography in primary and/or community care, supported by an expanded trained workforce of Cardiac Physiologists to meet the demands of service, thus negating the need for secondary services/interventions.
- Offered cardiac rehabilitation to all appropriate patients with cardiac disease, increasing the referral, uptake and completion rate to 70%, with an associated reduction in cardiac related admissions and improvement in outcomes.

Delivery planning

In order to achieve this, the CVD programme will initially focus on four priority areas, with work commencing from October 2019 onwards:

1. Development of a NICE guidance **standardised referral, diagnostic and management pathway for stable angina**, using CT angiography as the first line, where clinically appropriate
2. Co-design of a **pathway to improve identification of AF and optimised anticoagulation of AF**, thereby reducing incidence of stroke
3. Pilot schemes to **improve early access to echocardiography** to improve investigation of those with breathlessness and the early detection, and therefore evidence-based management, of heart failure and valve disease

Page 118 of 185

4. Testing of technology to increase the referral and uptake of cardiac rehabilitation.

Ambitions for CVD

Our future ambition is to expand the current scope of our UCV CVD programme to cover not just the areas where variation is more prevalent across Sussex, but also individual cardiology, stroke and respiratory programmes, to report to the unwarranted clinical variation board. This proposed structure would enable us to cover further LTP commitments related to CVD from 2020/21 when fair shares funding becomes available, such as: increasing the numbers of people treated for hypertension and high cholesterol; rehabilitation services; and more effective use of technology and innovation, including linking with the NHS genomics programme on expanding access to genetic testing for Familial Hypercholesterolaemia (FH). Our immediate focus on stable angina pathways, improving identification of AF, improving access to echocardiography, and using technology to increase uptake of cardiac rehabilitation will be re-evaluated in line with our proposed updated governance structure, which would give greater prominence to CVD treatment across Sussex.

We are committed to expanding our CVD services over the next five years to offer a comprehensive service across primary, secondary and tertiary care which delivers improved treatment and support. We will support the national roll-out of the CVDPrevent Audit when this occurs from March 2020. As the British Heart Foundation and Ambulance Service roll out defibrillator networks, we will work with these services towards the goal of improving out of hospital cardiac arrest survival to 25%. We are committed to stronger working with our voluntary partners, including with the British Heart Foundation through the Cardiac Rehab Network in Sussex and Surrey. We also look forward to taking advantage of further opportunities as the national CVD and respiratory programme develops the service specification for STEMI heart attacks.

Musculoskeletal services and planned care

Challenges

- Higher primary total hip and knee replacement surgical intervention rates, despite similar rates of osteoarthritis
- Poorer post-operative health gain
- Current fragility of MSK services across Sussex.

Future state

By 2023/4 we want to consistently deliver the best value MSK pathway within Primary Care focused on empowering self-management and conservative treatment approaches with appropriate and effective use of onward referral/post-operative rehabilitation. Based on their individual needs and choices, people with MSK conditions will have access to early treatment for their condition and support to develop the knowledge, skills and confidence to self-manage their condition and maintain their independence.

Changes to the MSK pathway are already having a significant effect on the sustainability of Trauma and Orthopaedic services in secondary and tertiary care settings, which have the potential to become more acute as a result of the pathway changes proposed. Under the auspices of the Sussex Acute Collaborative Network, we will put forward proposals to manage the transformational change required in order to ensure a sustainable future for

Page 119 of 185

these services across Sussex.

By 2023/24, we will have:

- A First Contact Practitioner workforce covering 100% of the population of Sussex.
- Provided access for people with MSK conditions, based on their individual needs and choices, to early treatment for their condition and support to develop the knowledge, skills and confidence to self-manage their condition and maintain their independence.
- Reduced growth in demand for GP consultations for MSK conditions, MSK medicines and imaging, physiotherapy, specialist MSK referrals and elective MSK surgery through delivery of a First Contact Practitioner model which will provide earlier assessment and management largely through conservative treatment options. This will also lead to better integration of services alongside use of an integrated digital record.

Delivery planning

The MSK UCV Programme of Works commenced in March 2019. To date, two large oversight groups, consisting of 50-60 people, have been held with stakeholder representation from every MSK Provider Health and Care Organisation across Sussex to begin to co-design MSK pathways.

Using Right Care and GIRFT data we have mapped current resources/pathways and identified gaps and opportunities for improvement across the system. Using a Best Possible Value decision charter, stakeholders have subsequently collaboratively agreed that the initial focus will be to co-create the best value evidence-based initial MSK pathway within wider Primary Care. This will be focused on empowering self-management and delivering conservative approaches, supporting, where appropriate, onward referral and post-operative rehabilitation.

The preferred solution option for a Sussex-wide First Contact Practitioner service model has now been defined and, following due governance and sign off, operational delivery will commence from April 2020. The solution will be tested for one year with regular evaluation/monitoring of impacts, with a view to longer term delivery from April 21 onwards.

Falls and fragility fractures

Challenges

- 3,100 additional falls in the over-65s in Sussex and East Surrey during 2017/18
- Higher rate of injuries due to falls in the over-65s compared to our demographic peers.

Future state

The LTP sets out plans to work on falls and fracture prevention, whereby a 50% improvement in the delivery of evidence-based care could deliver £100 million in savings nationally. The UCV Programme of Works supports this ambition and aims to have achieved the following by 2023/24:

- Significant savings by Year 5 through successful delivery of falls prevention services and fracture liaison clinics

Page 120 of 185

- Reduced demand for care through increased falls prevention.

Across Sussex, our aims are:

- A reduction in injuries due to falls among the over-65s, and therefore in activity and spend related to this in ED and NEL admissions
- Increased opportunities for people aged over 50 to access physical activity
- Improvement in bone health, and identification and treatment of osteoporosis, through equitable access to Fracture Liaison Services
- Increased appropriate referrals, according to risk, to evidence-based Strength and Balance classes, and multifactorial falls risk assessments
- Redesigned pathways to deliver timely support and response to people who have fallen at home, and a subsequent reduction in ambulance call-outs and response times to non-injured falls at home
- Improved falls prevention knowledge, skill and confidence in the over-65s
- Implementation of a consistent universal Home Hazard assessment.

Delivery planning

The Falls and Fragility UCV Programme of Works commenced in April 2019. Two Falls and Fragility oversight groups were held during April and June 2019 involving approximately 50-60 multi-professional stakeholders coming together to shape and scope opportunities to improve and drive value in falls and fragility fracture services across the STP footprint. The Best Possible Value Toolkit was implemented within each workshop to enable co-design of future services and pathways, demonstrating value through agreeing the context for change and identifying the key objectives to be achieved by the service/pathway redesign.

Together with our stakeholders, we have made a series of commitments that we will implement over the next five years:

- Delivery of increased Strength and Balance Programmes to reduce falls by 34%.
- Implementation of a Sussex-wide Single Point of Access to falls prevention services, ensuring that a person receives the right treatment first time.
- Development and implementation of standardised Home Hazard assessments to reduce recurrent falls after hospital attendance for a falls related injury. Expected Return on Investment of £1:£3.17.
- Equity of Fracture Liaison Services to reduce secondary fractures by 50%.
- An approach to supporting Ageing Well and improvements in bone health.
- An approach to reduce response times to ambulance calls for non-injured falls at home.

Participants in the stakeholder workshops concluded that there was a need to establish four short-life 'Task and Finish' groups to undertake some specific focused work to co-produce and redesign those elements of the pathway relating to the initial priority areas identified, namely:

- **Non-injured falls at home**: a focus on improving response times and reducing long-liers as well as referral onward to falls prevention services
- **Low level falls prevention & osteoporosis identification**: a focus on ageing well, improving bone health, identifying people at risk of falling, and empowering them to attend evidence-based falls prevention services, such as strength and balance programmes

- **Falls prevention post A&E attendance or hospital admission for a falls-related injury**: focus on onward referral to Home Hazard assessment and falls prevention services
- **Fracture liaison service development**: a focus on developing and standardising our identification of fragility fractures, osteoporosis treatment to reduce further fragility fractures and onward falls prevention.

Governance

The Unwarranted Clinical Variation Programme Board has oversight of the MSK, Falls and Fragility Fractures and Cardiovascular Boards and reports to the Clinical and Professional Cabinet. We have an executive sponsor, SRO, and clinical and programme leads who are driving forward our three priority areas. The governance structure and responsibilities of the UCV board are detailed below:
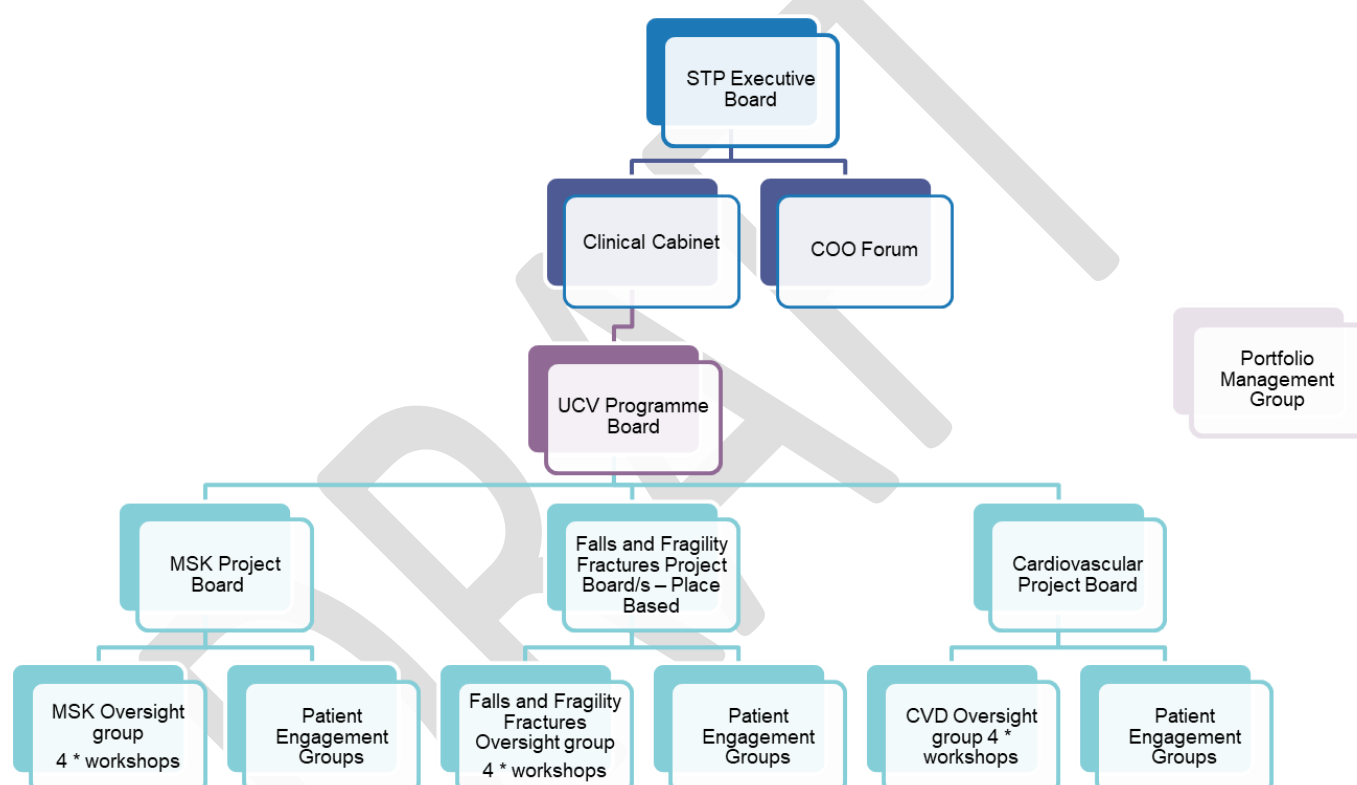
Figure 58: UCV governance structure

Approach and decision making framework

A common approach to programme delivery across the three priority areas was agreed at the outset which entails overarching governance and oversight of the programme as a whole, with a bottom-up collaborative approach to design. As part of this it was agreed that we would hold a series of four multi-agency/multi-professional workshops or 'Oversight Groups' per pathway, which are large forums involving all providers and commissioners in order to:

- Gain a shared understanding of the issues and opportunities
- Co-produce evidenced-based solutions to the unwarranted variation
- Develop and agree an overarching service model and pathways.

The UCV Programme has identified the Best Possible Value (BPV) Toolkit as an appropriate

Page 122 of 185

framework to help drive a common approach to collaborative decision making and has been subsequently endorsed by the UCV Programme Board. This approach aims to support:

- A value-based approach when redesigning services.
- Clear processes to improve the speed and ease of decision making
- The evaluation of options on the merits of maximising value
- Achievement of best possible outcomes for individual patients and the public within available resources.
- Implementation of agreed decisions sooner and with the support of all stakeholders.
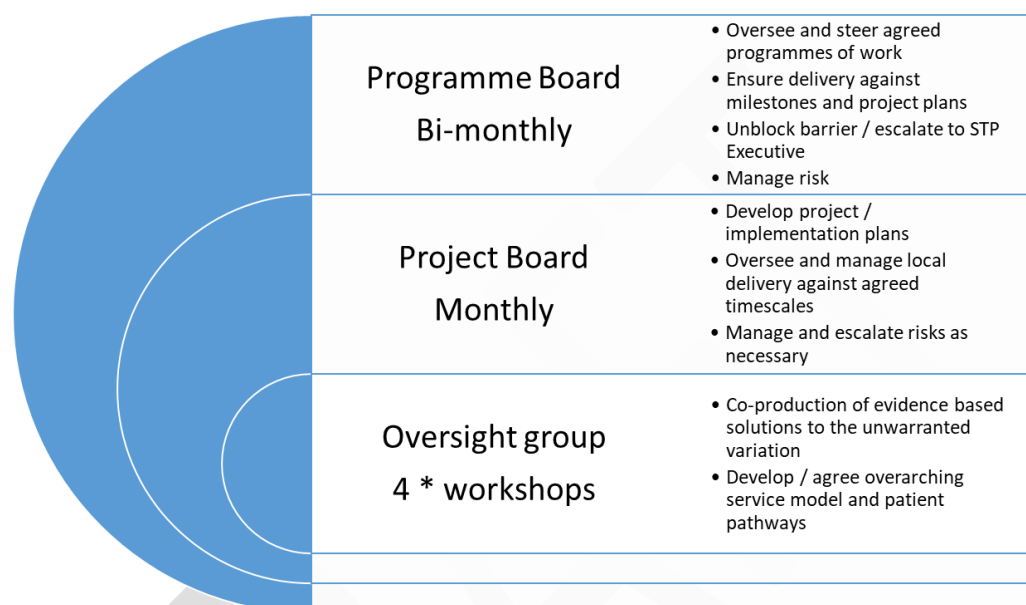
Figure 59: Responsibiltiies of the Board

Figure 60: UCV summary roadmap

For more information on the five year phasing of our actions to deliver our priority programmes, please see Appendix A. For further CVD commitments not prioritised for 2019/20, a detailed roadmap of actions and trajectories will be developed following the proposed expansion of the scope of the UCV programme.

Stakeholder mapping & engagement

The UCV Programme Team have recently developed an overarching Communications & Engagement strategy which aims to consult, engage and fully communicate the idea and concept of UCV and the workstreams to a variety of internal and external stakeholder audiences. It will build people's trust and confidence in the work taking place, the proposed new model(s), and how it impacts them, their work and their health and care.

Information provided will be clear, convenient to access and easy to find. We will use those channels already known to our target audiences:
1. **For internal CCG staff** – minimise duplication and link up interdependencies between programmes of work through the CCGs in Sussex
2. **For providers** – streamline activity to reduce variation in care/access to services
3. **Public and patients** – promote health and wellbeing and inform/engage patients in any changes in NHS care/services.

Page 124 of 185

The following major health conditions are specifically addressed because they are key priorities in the NHS Long Term Plan and represent a significant proportion of the long term conditions prevalent amongst our population. We also have a large number of programmes working to improve care for other major health conditions for our population which are not mentioned in this section.

Stroke

Current state, challenges and commitment

Stroke, a preventable disease, is the fourth single leading cause of death in the UK, and the single largest cause of complex disability. Stroke mortality has halved in the last two decades but, without further action, due to changing demographics the number of people having a stroke will increase by almost half, and the number of stroke survivors living with disability by a third, by 2035. Across Sussex in 2017/18, there were 2,566 stroke-recorded admissions on the Sentinel Stroke National Audit Programme (SSNAP): with no action, this number could rise to 3,849. In Sussex, we have made some significant progress transforming our stroke pathways which is reflected in our Stroke Sentinel National Audit Programme (SSNAP) scores, however we are committed to going further and faster to improve the outcomes for our patients with best practice personalised pathways.

Governance and delivery mechanisms

The delivery vehicle responsible for driving improvement and transformation will be the newly formed Integrated Stroke Delivery Network (ISDN), which will be implemented by April 2020. The new ISDN will provide a clinically-led, robust and integrated governance framework to support and assure the implementation and delivery of the new National Stroke Service Specification. The governance arrangements and infrastructure will be in place by March 2020. The ISDN geography has not yet been finalised, but we will work closely with neighboring ISDNs to manage patient flow across boundaries, including close collaboration with SaSH.

We are committed to actively involving stroke survivors, their families and carers in discussions and decisions about stroke care, in addition to our local voluntary and community sector partners such as the Stroke Association. We will establish suitable patient involvement and co-production arrangements so that people at risk of, or who have experienced, a stroke are represented from the outset in the governance arrangements of the new ISDN.

Our local ISDN will also be responsible for setting clear expectations across Sussex and leading local consultation and decision making on proposals for stroke service transformation. It will have three key deliverables:

- Best practice personalised stroke pathways configured and managed from pre-hospital care onward, including ambulance, thrombectomy, Early Supported Discharge (ESD) and six-month reviews within initial implementation, building to include the full pathway from prevention through to life after stroke
- A flexible, future-proofed competency-based stroke workforce delivering stroke care 24/7, supported by a skills and capabilities framework and toolkit
- A comprehensive dataset meeting the needs of clinicians, commissioners and

Page 125 of 185

patients, describing the quality and outcomes of care provided and ensuring that all providers are effectively inputting into SSNAP.

Our aspirations in Sussex

Prevention - We will deliver a more individual-centred approach focusing on prevention to align with the Sussex-wide CVD prevention strategy to reduce health inequalities. The ISDN will work with community pharmacists, GP practices, and voluntary sector partners such as the British Heart Foundation and the Stroke Association, to raise awareness of stroke and its symptoms, as well as risk prevention. This could include, for example, increasing the number of people treated for high blood pressure and cholesterol.

Whist we have seen improvements in relation to the identification and management of Atrial Fibrillation (AF) there are still an estimated 13,750 people with undiagnosed AF within Sussex. The ISDN will continue to work closely with Primary Care Networks and the Sussex-wide UCV programme so that by 2021/22 we have a consistent approach across Sussex, with direct learning from the CVDPREVENT audit. Our longer-term aim within our prevention strategy is that, by April 2029, 85% of the expected number of people with AF are diagnosed and 90% of patients with AF who are known to be at high risk of a stroke are adequately anticoagulated. The impact of this will be 436 fewer strokes across Sussex.

Acute care – The Sussex acute care plans will ensure that we maximise patient care and system sustainability via service transformation and reconfiguration. We will work closely with SECAmb during 2021/22 to deliver robust transfer pathways including category 2 intra-hospital transfers for potential thrombectomy patients. This will include training and operational capacity to support the increase in thrombectomy at Brighton and Sussex University Hospitals (BSUH) and the acute service transformation planned in West Sussex for 2021/22. Capital funds are also being considered.

By 2023/24, we aim to have increased the provision of stroke thrombectomy for 10% of patients. We are committed to increasing mechanical thrombectomy provision from an ad hoc five day service to a comprehensive 24/7 service over a period of six years at the Brighton and Sussex University Hospitals (BSUH). This would increase the number of thrombectomies from 29 (2017/18) to 359 by year six. This modelling assumes thrombectomies from BSUH, East Sussex Healthcare, Western Sussex Hospital Trust, East Surrey Hospital and Tunbridge Wells Hospital (Pembury) are referred to BSUH (Royal Sussex County Hospital) for treatment.

By 2021/22 we will have all acute stroke system transformation completed across Sussex, with all stroke services delivered in fully compliant HASU/ASU units delivering sustainable 7 day services with a competent reshaped workforce to enable consistent achievement of overall quality marker of SSNAP A performance across all systems. We will deliver thrombolysis to at least 15.8% of stroke patients and stroke unit care in less than four hours for at least 80% of all stroke patients, in order to reduce disability and increase survival after a stroke. Further detail on our targets is set out in the Strategic Planning tool.

The ISDN will also ensure that TIA and stroke 'mimic' activity, including neurology patient flow, is considered within all service modelling, development and transformation, and that we

develop plans for the implementation of AI imaging software in line with the national pilot outcomes.

Rehabilitation – The ISDN will work to ensure that Sussex delivers the new national standards for both inpatient and integrated community rehabilitation services in 2020/21. We will implement the Early Supported Discharge (ESD) pathway for Coastal West Sussex during 2020 and meet the 40% ESD standard across Sussex by 2021/22.

We will adopt the new national CQUIN and ensure that all stroke survivors across Sussex are appropriately offered a six month post stroke review with a minimum of 60% uptake by 2021/22. We will ensure that data is systematically collected from the six month reviews across Sussex and used to inform local needs mapping, as well as workforce and service improvement planning, for 2020/21 and subsequent years. Further detail on our targets are set out in the strategic planning tool.

The ISDN will also pull together a comprehensive offering for Stroke Survivors and their families and carers, supporting engagement and access to long term rehabilitation including self-management, vocational support, psychological support and social prescribing, with the aim of improving community integration.

Diabetes

Current state and challenges

Across the Sussex Partnership, the healthcare system faces a number of significant challenges relating to the delivery of diabetes care. We have a diverse population with extreme variations in terms of socioeconomic status, health outcomes, environment and economic prosperity, all of which are linked to health inequalities and outcomes.

East and West Sussex have a much older population profile than the country as a whole, whilst Brighton and Hove have a younger population profile. Poor diet has been identified as one of the top five factors driving variation in outcomes, alongside smoking rates, lack of physical activity, alcohol misuse and mental health problems.

We face challenges in meeting constitutional standards; for example, while NICE recommend referral and triage within two days, 83% of our patients wait more than two days and 38% wait at least 14 days.

Diabetes outcomes also have significant variation, with a wide variation in amputation rates across Sussex, and the diabetic amputation rate expected to continue rising. The average number of major amputations in England is 8.1 per 10,000 (standardised rate). Across Sussex, the rate ranges from 5.8 in High Weald Lewes Havens CCG to 10.2 in Eastbourne, Hailsham and Seaford CCG. The average number of minor amputations in England is 20.7 per 10,000 (standardised rate). Across Sussex, the rate ranges from 17.7 in Crawley CCG to 28.9 in Eastbourne, Hailsham and Seaford CCG.

There remains a gap in the actual to expected prevalence rate of diabetes across all CCGs. To address this we are focusing on primary care screening for diabetes, with some CCGs providing financial incentives to encourage this.

The Sussex Diabetes Programme has been established to support each place within our footprint to identify commissioning gaps, deliver improvements in the services each place offers, deliver improvements in the health outcomes of people living with diabetes, and reduce unwarranted variation.

Our aim is to create a sustainable system of diabetes care within Sussex that supports the prevention of diabetes, allows people living with diabetes to easily access high quality services when needed, supports people to self-manage, and attracts and retains the best diabetes workforce. We will also aim to work collaboratively with the newly established Sussex Health and Care Partnership Prevention Board to develop the public health interventions that could support primary and secondary prevention, with the long term aim of stemming the tide of preventable diabetes and encouraging greater self-care and understanding of people living with the condition.

Remit of the Programme

The Sussex Diabetes Programme is currently focused on six priorities to achieve our vision:

1. **Prevent Type 2 Diabetes Mellitus (T2DM)**
The Programme will support delivery of the National Diabetes Prevention Programme. A new NDPP provider is transitioning in and will go live in August 2019, and we have recruited an NDPP project manager. We have set targets for referrals that will contribute to the national DPP uptake, through the place-based commissioners.

2. **Improve diabetes footcare**
The programme will support the implementation of the Sussex Multidisciplinary Foot Project and seven day access to urgent consultant led foot services. Each place will have projects to recruit DISNs and ensure universal MDFT provision across Sussex, with clear links and pathways with the vascular hub.

Identified next steps include:

- Implement root cause analysis (RCA) process across all providers
- Install foot care champions on all wards (including digital solution to identify all inpatient diabetics)
- Develop foot care education offer for HCPs
- Commission peer review of foot services
- Embed clinical audit improvement across STP – NDFA and Harms

3. **Improve patient outcomes**
The programme will support the delivery of quality mental and physical health diabetes care, the achievement of CCG Improvement and Assessment Framework Targets, and reducing unwarranted variation. Our focus will include:

- Utilisation of the CCG Improvement and Assessment Framework
- Attendance at structured education in the prevalent diabetes population (%) (source: NDA)

Page 128 of 185

- Achievement of the three NICE recommended treatment targets in patients with type 1 diabetes (source: NDA)
- Indirectly standardised 3-year rate of amputations in patients with diabetes (source: Public Health England)
- Directly standardised rate of bed-days for patients with diabetes admitted to hospital (source: Hospital Episode Statistics and NDA)
- Multidisciplinary foot care team coverage and diabetes inpatient specialist nursing service coverage across a CCG's commissioning footprint (source: NDA – National Diabetes Footcare Audit/National Diabetes Inpatient Audit)
- Achievement of NICE recommended treatment targets in children (source National Paediatric Diabetes Audit).

4. **Have fair and consistent policies for CGM/FGM**

The programme will support all SES CCGs to have compliant policies for CGM and FGM. The NHS Operational Planning and Contracting Guidance 2019/20 sets out requirements for the provision of CGM and FGM. Our plan is that, by 2020/21, all pregnant women with type 1 diabetes will be offered continuous glucose monitoring (CGM), helping to improve neonatal outcomes. In line with guidance, we have ensured that flash glucose monitoring is available for type 1 diabetes patients who meet the criteria.

5. **Support people living with diabetes to self-manage**

The Diabetes Programme will support the roll-out of a consistent, high quality digital self-management offer across Sussex. This will include:

   a. Patients Know Best – patient held health record
   b. DUK information prescriptions
   c. Online Diabetes Self-Management Education (DSME) – T1DM, T2DM and transitioning patients

6. **Support frail older people to live independently and to improve outcomes in care homes**

We will support development of new inpatient nursing and proactive community nursing roles to support independence, and to reduce admissions, readmissions and length of stay. We will also support the development and roll-out of training and support packages to nursing homes to support good diabetes care in the care home environment.

Governance

Hastings & Rother CCG are the host organisation and budget holder for the Sussex Health and Care Partnership Diabetes Programme, and are responsible to NHS England for delivery of the programme, reporting into the Programme Board.

Key roles and responsibilities include:

- The STP programme manager and senior responsible officer (SRO) chair and administer of the STP Diabetes Oversight Group (DOG)
- The STP multidisciplinary foot project team are line-managed by the STP programme manager
- NHS South, Central and West Commissioning Support Unit provide business intelligence and analytics

Page 129 of 185

- Hastings & Rother CCG Programme Management Office (PMO) provide PMO support on behalf of the STP.

Respiratory

In line with the national picture, respiratory disease is one of the greatest contributors to morbidity and mortality in Sussex. Our ambition is to shift activity closer to patients' homes, using a model of community and primary care services, improving early identification, and optimising management to prevent acute exacerbations and admissions.

To integrate respiratory services into the community model, places have been tasked with developing local responses to the commitments of the Long Term Plan and setting out their tailored approach to improving respiratory services and outcomes within their patch. A number of priorities are emerging from the current work within places, including scoping to offer the myCOPD app to patients more widely in collaboration with community teams. Longer term, our aim is for all our services to be able to provide community support to patients with a wide range of respiratory-related conditions, reducing the need for these patients to travel out-of-area for specialist aftercare.

Community respiratory services are also being developed and enhanced to reduce admissions from respiratory conditions and manage various levels of complexity of condition across primary care, general and specialist community services. The COPD, respiratory and chronic respiratory LCSs are being reviewed in Brighton & Hove and East Sussex to identify opportunities to enhance training, review medication, and scope alignment with currently-developing PCNs. By reviewing our training programmes and pathways, we can support staff to counsel patients and empower them to take a more active role in their care.

More detail on the implementation of respiratory service changes can be found for each place in Appendices A-D.

8. Supporting our workforce

8.1. Current state and key challenges

Workforce is critical to the delivery of the health and care strategy: we also know that, at present, the health and care system faces a number of challenges to ensuring that it has the workforce to achieve its current and future needs.

Key workforce challenges in Sussex:

- High vacancy rates – notably in a number of registered health professional groups such as nursing, medical staff and allied health professionals
- Higher turnover rates in recent years
- Insufficient supply of future staff to key roles based on current staffing models.

Leaders across the Sussex Health and Care Partnership are committed to working collaboratively to address these challenges and to deliver upon the commitments of the interim NHS People Plan through the development of our Sussex workforce plan, strategic priorities to 2023/24, and system approach to delivery.

8.2. Sussex workforce plan

The first step in developing our workforce plan has been to model what our workforce demand would be if we continued to operate using current workforce and operating models with a staff supply that continues to increase at the current rate. This default position for our workforce over the next five years has been commissioned by The Local Workforce Action Board (LWAB) and Finance Group to produce this *'do nothing'* model based on agreed activity growth from 2019/20 plans and agreed activity modelling. This demonstrates a growing workforce challenge over the next five years and is the baseline from which plans will be developed.

The tables below represent the overall and staff group forecast position in a 'do nothing' scenario, before the impact of the Partnership plans over the next five years.

The 'do nothing' projection for workforce forecasts an overall 11.2% workforce gap in 2023/24, representing 3,920 WTEs.
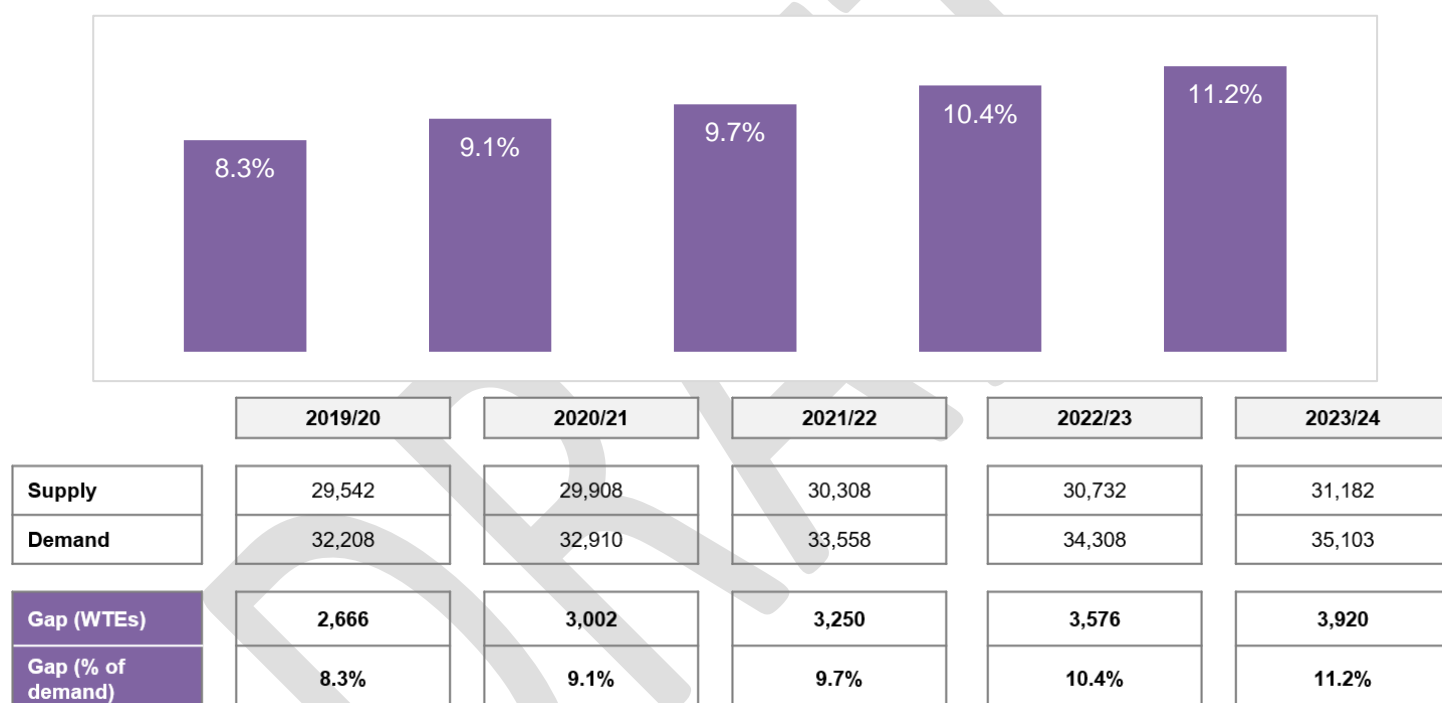
	2019/20	2020/21	2021/22	2022/23	2023/24
Supply	29,542	29,908	30,308	30,732	31,182
Demand	32,208	32,910	33,558	34,308	35,103
Gap (WTEs)	2,666	3,002	3,250	3,576	3,920
Gap (% of demand)	8.3%	9.1%	9.7%	10.4%	11.2%

Figure 61: 'Do Nothing' workforce projection

The workforce gap is forecast to increase most significantly for Nursing, Midwifery and Health Visiting staff, to 20.1% in 2023/24
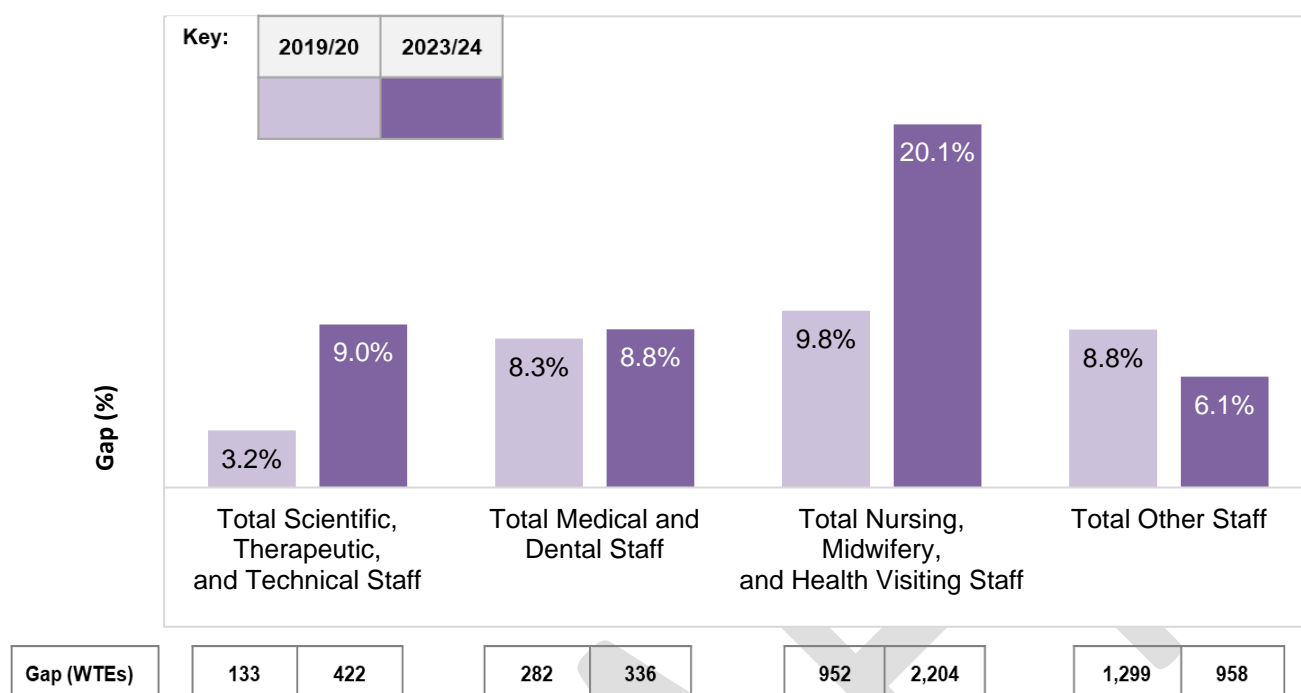

Key:	2019/20	2023/24

Gap (WTEs)	133	422		282	336		952	2,204		1,299	958

Figure 62: 'Do Nothing' workforce projection by staff group

Changes in workforce demand

There are a number of factors that will influence workforce demand in the next five years:

- Under the Additional Roles Reimbursement Scheme for Primary Care Networks, the primary care workforce has been modelled to increase by over 650 wte clinical pharmacists, social prescribing link workers, physiotherapists, physician associates and paramedics.
- NHS providers' organisational plans show that workforce developments will increase workforce demand by c.1,100 wte. This increase is based upon the plans of the system's mental health and community providers specifically, on the back of additional investment in these sectors. Acute providers' 'do something' workforce plans have not yet been worked up in sufficient detail to generate specific numbers for changes to their baseline workforce demand projections.
- More detailed workforce plans will be developed for Sussex-wide and place-based priority clinical programmes over the coming months, as details of operational plans and activity impact are developed and agreed collectively. These plans will consider the opportunities for new roles and new ways of working, including the opportunities for improving care through technology and digital.

Changes in workforce supply

The Partnership recognises the importance of developing plans to improve the future supply of workforce, particularly for key staff groups such as nurses and AHPs, where a training programme may take several years to complete. To address the supply of workforce:

- Partner organisations in Sussex are already collaborating to optimise use of the

Page 132 of 185

apprenticeship levy as a new route into health and care careers, including, where appropriate, transferring the levy to other health and care providers

- Plans are being developed to promote health and care careers to the local population and to promote Sussex as a place to work and live
- We are reducing staff turnover – the approach to making Sussex the 'Best Place to Work' is described in more detail in the section below
- We are developing capacity to train more staff within Sussex
- We are developing new roles to manage demand differently and the associated education commissioning required.

Workforce plans will be developed to align with the Sussex Health and Care Strategic Model by supporting planning at neighbourhood, place and Sussex level. This will be vital for ensuring alignment of the workforce with clinical models, activity and finance, and for supporting the development of our new service model, taking into account the needs of PCNs and ICPs.

8.3. Workforce strategic priorities – delivering the interim NHS People Plan

The Sussex Partnership has recently reviewed and agreed strategic workforce priorities for 2019/20. The timetable for strategic priorities from 2020/21 to 2023/24 is outlined later in this section and is designed to align with system priorities and anticipated progress on the NHS People Plan at a national level.

The workforce workstream strategic priorities for 2019/20 are designed to align closely with the priorities within the Long Term Plan Implementation Framework and with key local needs. Our initial priority will be NHS employers, and we will work with other partners within the Sussex health and care system in the future to develop our workforce strategy further and to share and codify learning.

Our strategic priorities for 2019/20 are set out below under the following themes:

- Workforce planning, transformation and growth
- Making the NHS the 'Best Place to Work'
- Improving leadership culture
- Changing the Workforce Operating Model

Workforce planning, transformation and growth	
Strategic objective – 2019/20	**Our approach to achieving this objective**
Produce a workforce plan to 2023/24 aligned to activity and financial plans for Sussex Health and Care Partnership	The approach to workforce planning is described in the Sussex Health and Care Partnership workforce plan section above
Produce more detailed workforce plans for health professional groups – for 2019/20 the focus will be on producing a nursing workforce plan and AHP workforce plan	A detailed nursing workforce plan will be developed during 2019/20. This will outline plans to manage workforce demand differently (e.g. e-rostering efficiency, assigning clinically appropriate alternative roles to registered nurses, system transformation and workforce redesign) and to increase workforce supply (e.g.

Page 133 of 185

	opportunities to increase international and domestic recruitment, improve retention, increase newly qualified nurses through universities and apprenticeships). A similar plan will be developed for the most challenged Allied Health Professionals staff groups.
Improve primary care workforce development by implementing the Sussex Partnership Training Hub development plan – focusing on improved workforce planning, engagement with Primary Care Networks, improved education quality assurance and governance	We have established a central team for the Training Hub and continue to invest in local training hubs. With the support of Health Education England, primary care team plans for Sussex-wide and local training hubs will continue to develop and learn from other STPs. The focus will be on supporting the current workforce and developing the future workforce, with a specific focus on the Primary Care Network workforce.
Implement reductions to nursing agency costs and agree a collective approach to reducing NHS provider medical agency costs	Whilst the workforce strategy is to reduce our overall workforce gap, we recognise there are opportunities to reduce current temporary staffing costs. The focus to date has been on reducing nursing agency costs, with additional reduction actions planned in 2019/20. We are also working with the NHSI/E temporary staffing team to develop our strategy to reduce medical agency costs.
Make the NHS the 'Best Place to Work'	
Implement a plan to improve staff mental and physical health and wellbeing, promote flexible working, reduce violence towards NHS staff, and adopt best practice to close the ethnicity gap in rates of disciplinary action	Whilst the NHS Staff Survey shows that staff experience in most NHS organisations in Sussex is better than the NHS average, we recognise there are significant opportunities for improvement to make Sussex the 'Best Place to Work'. We have developed a prioritised programme of work within the Health and Care Partnership to improve the experience of our staff at work, building on best practice within our system and learning from others. We believe that our collective approach will reduce staff turnover by at least 2%.
Undertake diagnostic on priority action to improve Black, Asian and minority ethnic (BAME) staff representation across the STP leadership team and	We recognise the importance of workforce race equality within employers in the Partnership, but also acknowledge from the Sussex-wide review of our current Workforce Race Equality Standard (WRES) position, that

broader workforce by 2021/22	we need to improve.
	We are working with the national WRES team to develop our workforce race equality strategy, including responding to the *Model Employer* strategy to improve BAME representation across the workforce pipeline and at leadership levels. The strategy will be shaped by a Sussex-wide event for chief executives, race equality leads and other senior leaders in November 2019, to identify priorities for workforce race equality and develop plans to address them.
	Our Best Place to Work Group is leading on learning from *A Fair Experience for All* to improve the fairness of disciplinary processes for all staff, and close the gap in the disproportionate rates of disciplinary action involving BAME and white staff within our organisations.
Improving leadership culture	
Establish and embed the cultural values and behaviours we expect from our senior leaders	Senior leaders in the Partnership recognise that positive, compassionate and improvement-focused leadership creates the culture that delivers better care, and that operating as an Integrated Care System will require a different approach to leadership.
	Defining the leadership cultural values and behaviours of senior leaders and how they will be embedded will be a focus within the ICS Accelerator programme.
Implement a system-wide approach for managing talent that aligns with Regional Talent Board	We recognise the importance of developing the talents of our staff.
	We are developing our approach to talent management with the support of the KSS Leadership Academy.
	We will ensure our approach aligns with the emerging approach of the NHS South East Regional Talent Board, established earlier in 2019.
Agree a prioritised leadership development plan for 'connecting layer' of management	We have a number of programmes within Sussex to support and develop leaders. These include the development of a Sussex coaching network and a leadership development programme for frontline leaders. These programmes are supported with funding from Health Education England and the KSS Leadership Academy.
	We are also working on a leadership development programme for the 'connecting' layer of management.

Working in partnership across Sussex

	The development of these programmes is overseen by a multi-agency staff development group involving NHS, local authority and other health and care providers.
Change the Workforce Operating Model	
Agree Integrated Care System level workforce responsibilities with NHSI/E and HEE, including a transition plan and future resources	We will develop our workforce operating model to transition to an ICS with NHSI/E, learning from the STP/ICS Workforce Planning Development Tool pilot sites.

Working in partnership across Sussex

8.4. Strategic plan from 2020/21 to 2023/24

This section outlines the phasing of the workforce workstreams in future years.

The future plans are phased to reflect Sussex workforce priorities and in anticipation of local devolution of actions from the final NHS People Plan. The phasing is subject to adjustment following publication of the final NHS People Plan and/or NHSI/E guidance.

The plan aims to initiate further actions between 2020/21 and 2021/22, with the focus in 2022/23 and 2023/24 on delivering the impact of the interventions started in the previous three years and refining their approaches.

Theme	2020/21	2021/22
Making the NHS the 'Best Place to Work'	• Embed actions to improve mental and physical health, reduce violence, and increase flexible working • Implement new NHS offer to staff • Implement actions from Sussex WRES diagnostic • Undertake diagnostic to improve disability equality using WDES • Introduce new NHS 'balanced scorecard' and metrics in NHS Oversight Framework	• Implement recommendations from national independent review of HR and OD practice • Embed actions from workforce disability diagnostic
Improving the leadership culture	• Implement new NHS Leadership contract • Continue to deliver STP leadership programmes • Review Partnership leadership programmes based on evaluation • Embed talent management systems • Increase number of participants in graduate management scheme in Sussex	• Support further maturing of talent management systems • Review impact of system-wide leadership programmes
Addressing urgent shortages in nursing	• Continue to implement Sussex nursing workforce plan – improved supply, new roles etc. • Increase nursing university clinical placements and engage with universities to facilitate further increase • Embed Sussex nursing careers framework in NHS providers • Align Sussex recruitment activity with new national recruitment campaigns • Implement collaborative approach to international recruitment aligned	• Increase nursing clinical placements • Fully embed nursing careers framework in all sectors

Page 137 of 185

	to new national guidance	
Delivering 21st century care	• Implement locally national changes to medical education content and distribution of trainees developed by HEE (from IPP) • Implement locally *Maximising the Potential* report (SAS doctors) • Implement AHP workforce plan – focus on most challenged specialties • Develop workforce plan for medical staff • Support further maturing of primary care Sussex Training Hub • Implement locally national digital workforce programmes – including training needs assessment with Sussex and action plan	• Develop workforce plan for scientific and technical roles, and other roles • Support full maturation of primary care Sussex Training Hub • Further roll-out digital maturity development plan • Fully streamline induction and on-boarding processes
A new operating model for workforce	• Implement roles and responsibilities for workforce agreed with Regional Team for STP/ICS	• Fully embed ICS workforce responsibilities agreed with Regional Team

8.5. System approach to delivering our workforce priorities

Sussex has a well-established Local Workforce Action Board (LWAB), which is responsible for developing and delivering the workforce strategy for the Sussex Partnership. It is co-chaired by a Trust Chief Executive and Local Director for Health Education England and meets every two months.

At this stage the membership of LWAB is primarily NHS organisations in Sussex, local hospices and Skills for Care. Engagement of local authorities on workforce priorities will develop alongside their wider engagement in the Health and Care Partnership.

The LWAB also oversees the use of external funding for workforce development – primarily from Health Education England and the KSS Leadership Academy.

Strategic priorities for workforce have been agreed by the Partnership Executive Group.

The Directors of Nursing/Directors of Human Resources Group, chaired by the STP Workforce Director and reporting to LWAB, meets each month to progress the strategic priorities agreed by LWAB, and coordinate delivery of the strategy. The membership of this group is Directors of Nursing from NHS organisations and a number of other partner organisations, NHS provider Directors of Human Resources, chair of the AHP Council, and representatives from Health Education England.

Five sub-groups responsible for leading specific strategic priorities and are jointly chaired by a Director of Human Resources and Director of Nursing from a partner organisation:

- Securing Future Workforce Group
- Strategic Workforce Planning Group

Page 138 of 185

- Leadership Development and Talent Management Group
- Best Place to Work Group
- Collaborative Resourcing Group

The SES Training Hub focusses on the primary care workforce, and also reports to the Sussex Primary Care Board. Infrastructure costs for the Training Hub are provided by Health Education England, funding a central team and local training hub teams.

The development of work programmes to deliver strategic priorities is supported by a Sussex Partnership workforce team. This includes a Sussex Workforce Director, who is the senior responsible officer for the programme including coordination of the Partnership workforce strategy, a Strategic Nursing Workforce lead, and project leads who support designated projects.
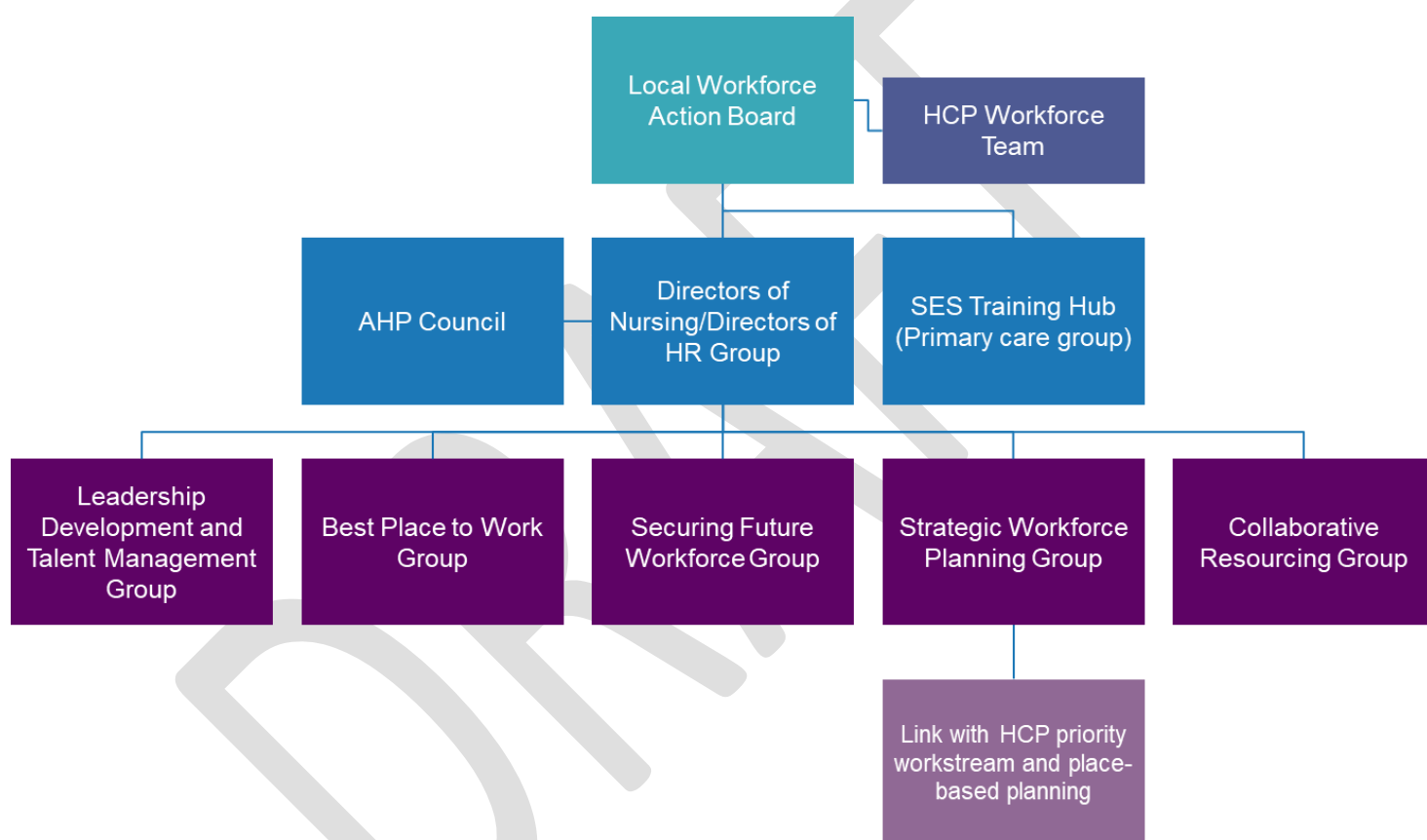

Figure 63: Our workforce programmes

8.6. Key assumptions

The key assumptions for the workforce strategy are:

- Assumptions used in workforce planning are valid for overall projection of future workforce demand and supply.

- Actions planned by Sussex Partnership have the scope to be successful. For example, there is the potential to increase the number of people working in health and care professions to the level described in the plan.

- National/regional funding and support will be sufficient to deliver all aspects of the NHS People Plan, including significant increases in continuing professional development funding

and funding to support increases in clinical placements.

- Further national guidance is provided to the timetable set out in the interim NHS People Plan.

Key workforce risks are provided in section 10.4 on major risks and mitigating actions.

Page 140 of 185

9. Supporting effective delivery: Our Sussex-wide enablers

9.1. Digitally-enabled care

9.1.1. Current state

Governance

The Sussex Health and Care Partnership has placed a strong priority emphasis on rapidly developing the culture and digital maturity of its partner organisations over the past couple of years. Sussex has strong, mature leadership and governance in place with its system and sector-wide Digital Programme Board, which is Chaired by a trust Chief Executive with accountability as Executive Sponsor of the Digital Programme. Reporting into this group are the Sussex Wide Information Governance Group, chaired by the Chair of the National SIGN group, and Design Authorities for developing and maintaining cyber-security, digital standards and shared infrastructure. The newly-established Clinical and Professional Informatics Leaders Forum is bringing together CCIO, CNIO, Clinical Digital Leads and patient representation as a strategic advice group which can advise both the Digital Programme Board and the Clinical & Professional Cabinet, and develop ethical and clinical positions, protocols, and approaches for adoption by the wider Sussex system. We will also collaborate closely with our neighbouring systems during the course of our digital development, including with relation to shared health and care records.

Ambition

Working with clinical and professional leadership and the Partnership Executive team, Sussex has established a clear Digital Ambition which supports the delivery of the Sussex health and care strategic model:

"Seizing the opportunities of digital, data and technology to help our citizens, communities, clinicians and professionals securely redesign our health and care for our future."

This ambition is underpinned by four key themes, with the outcomes developed and agreed by the Clinical and Professional Cabinet:

- Our Provider's Digital Maturity
- Our Connected Health and Care System
- Our Digital Services for our Population
- Our Data for Population Health and Research

Sussex has developed and collectively agreed at Digital Programme Board, STP Executive and Clinical Professional Cabinet its initial roadmap through to 2024, and programmes of work including its approach to developing a Local Health and Care Record.

9.1.2. Our Provider's Digital Maturity

Sussex has a diverse starting position with regards to the digital maturity of its providers, which is acknowledged by partners. Therefore, a key principle of the planning approach over the last two years has been to target investments to close the gaps and unwarranted variation in the maturity of providers so they can all act as strong digital partners in our system. For example, recognising our relative challenge compared with national maturity levels, key clinical priorities, and the variation within our system, we have targeted investments to improve the coverage of Electronic Prescribing

and Electronic Observations, and to converge Order Communications systems to ensure that all providers across Primary, Community and Secondary Care will be able to work seamlessly across our system and to remove workforce barriers to working flexibly across Sussex. Following the recent reorganisation of our Sussex Partnership, the digital maturity of Surrey Heartlands and providers such as SaSH remains important to our system-wide development, therefore we will continue to develop our close relationships with neighbouring systems. The tables below show, first, the collective STP provider digital maturity position in 2016/17 against national rates and, secondly, the variation between providers which informed the prioritisation of investments.

Sussex and East Surrey 2016
Sussex and East Surrey 2017

Figure 64: Collective STP provider digital maturity position in 2016/17 against national rates. The grey and green bars are national averages in 2016 and 2017 respectively. Note that Business and Clinical Intelligence Data was not collected in 2016, hence the zero.

Organisation	Strategic Alignment	Leadership	Resourcing	Governance	Information Governance	Records, Assessments & Plans	Orders & Results Management	Transfers Of Care	Medicines Optimisation	Decision Support	Remote & Assistive Care	Asset & Resource Optimisation	Business & Clinical Intelligence	Standards	Enabling Infrastructure
Brighton and Sussex University Hospitals NHS Trust (General)	38	28	50	50	65	35	48	68	17	27	45	45	61	54	78
East Sussex Healthcare NHS Trust (General)	85	81	60	83	62	47	45	53	15	23	15	36	66	31	56
Queen Victoria Hospital NHS Foundation Trust (General)	80	63	85	58	84	27	25	56	8	0	35	40	59	29	61
South East Coast Ambulance Service NHS Foundation Trust (General)	90	89	90	92	90	53	0	56	31	0	0	58	95	43	88
Surrey and Sussex Healthcare NHS Trust (General)	95	94	90	96	97	47	93	70	8	45	60	60	89	67	84
Sussex Community NHS Foundation Trust (General)	80	84	75	79	88	60	16	35	3	64	30	57	45	42	59
Sussex Partnership NHS Foundation Trust (General)	95	94	90	88	94	73	10	36	2	56	69	83	82	75	97
Western Sussex Hospitals NHS Foundation Trust (General)	100	88	90	96	80	62	65	77	74	70	40	50	91	96	89
Sussex & East Surrey Average 2017	83	78	79	80	83	51	38	56	20	36	37	54	74	55	77

Figure 65: Variation in digital maturity of providers

Building upon the strong collaborative culture we have developed as a community, the Digital Programme Board and Clinical and Professional Informatics Leaders Forum have started to focus on developing a digital culture across the workforce and understanding the skills and workforce required for our digital future. Examples of this in practice include the successful 'IG By the Sea' and Sussex Digital Conference events in recent months, and the sharing of good practice business cases and co-production of bids, demonstrating the growing desire and confidence of teams and organisations to work as a digital community of practice and build a shared culture.

Sussex has already achieved reasonable digital maturity in primary care with GP IT services facilitating and recording millions of interactions with patients every week. GP practices have led the way in the move from paper to digital record-keeping and now offer online transactions, such as appointment bookings, repeat prescriptions, and video consultations. The current focused work in supporting improvements in digital maturity for GP practices is on hardening cyber security, Windows 10 deployment, the move to shared cloud storage services and implementing digital dictation, while working to understand the emerging needs of Primary Care Networks and the potential opportunities of a Digital First Primary Care approach. We aim to meet all mandated cyber security standards with 100% compliance across our NHS organisations by summer 2021, as set out in the Strategic Planning tool. Cyber security standards are coordinated through a formal sub-group of the Digital Programme Board. Monitoring and escalation up to Partnership Executive will be used as required, recognising the collective risk posed to Sussex partners and the Health and Care System as a wider community.

9.1.3. Our Connected Health and Care System

Access to integrated information across our system has been identified by clinicians and professionals as a critical challenge, recognising that the lack of it poses a barrier to redesigning services effectively and delivering new models of care at all levels. Significant progress has been made over the past two years, with shared approaches to information governance in support of information sharing now established, and the first place-based shared record access implemented in East and West Sussex across primary, community, mental health, acute and social care settings. These approaches are developing further under the agreed 'Our Connected Care' product developments within our broader 'Our Local Health and Care' programme. In the development of our Digital Ambition, the Clinical and Professional Cabinet clearly identified this as being the most urgent priority for our system. Strong enabling work has been underway across the Urgent and Emergency Care programmes, ensuring that care plans can be shared more effectively, and unlocking access to key information for the ambulance service. Sussex prioritised effective engagement and utilisation of national systems (SCR/AI, CP-IS) before developing its local services, with the result that we have strong access to these in Urgent and Emergency settings and more than double the national average of Frail Patients with SCR AI available.[14]

9.1.4. Our Digital Services for our Population

Developing new digital services for our population has been a key enabler for prevention, a system-wide priority, supporting self-management and the redesign of relationships between clinicians and patients. We are now rolling out our Personal Health Records for patients across our system: this is live in West and East Sussex for outpatients, and moving into supporting the first targeted pathway redesigns in cancer follow-up and diabetes. Sussex has a history of innovation in this area, with the Virtual Fracture Clinic model developed locally and now scaled and implemented within many providers across the country.

In addressing the Urgent and Emergency Care needs of the population, 111 Online has been successfully implemented along with direct appointment booking into our first Urgent Treatment Centres from the 111 service. In Primary Care, Sussex was an early adopter in both the Beta and Live phases of the NHS App, and a targeted Digital First primary care offer is being developed in East Sussex, with the learning being shared with the wider Partnership. Online consultations are also already live and seeing good take-up in East Sussex GP Practices, again with the learning

---

[14] NHS Digital Data 2019

Page 144 of 185

being shared with wider Sussex partners to inform their offer and deployments, while in the Brighton & Hove and High Weald Lewes Havens areas, TeleHealth for Care Homes pilots are now underway to test and understand the way these offers can be developed and then scaled across the wider system. We will continue to promote the uptake of the NHSApp amongst our population, please see the Strategic Planning tool for more details.

9.1.5. Our Data for Population Health and Research

Sussex is currently developing the Sussex Integrated Dataset, a pseudonymised linked dataset drawn from and supporting all partners in Population Health Intelligence, Research and Analytics. We are working with the support of the team behind the Kent Integrated Dataset, learning from their experience while tailoring the solution for the needs of our service areas. We are also sharing the learning from the experiences at neighbourhood and place-based levels, for example in the Horsham, Mid Sussex and Crawley areas, where neighbourhood level population health management has been well supported with linked dataset and risk stratification, helping target and evaluate services and outcomes effectively for local populations.

Key to our success in learning from experiences is the emerging community of practice around Analytics and Intelligence work, with developing partnerships across Primary Care, Community and Secondary Care, Mental Health, Public Health, local authorities and the police, as well as the support of the Academic Health Science Network and the engagement of academic partners in our local universities.

DIGITAL AMBITION

Seizing the opportunities of digital, data and technology to help our citizens, communities, clinicians and professionals securely redesign our health and care for our future.

Our Providers' Digital Maturity

Making sure that all providers across primary, community, secondary and social care can act as digitally mature partners in redesigning and delivering our health and care services.

Our Digital Services for our Population

Ensuring our digital relationship with our patients and population enables self-management, channel shift and effective and efficient use of patients and professionals time.

Developing trusted, timely, integrated digital care records, processes and communication tools, accessible to all appropriate clinicians and professionals.

Our Connected Health & Care System

Data is brought together at scale for a learning community to develop, test, plan and evaluate the evidence and effectiveness of services and innovations

Our Data for Population Health & Research

Figure 66: Our digital ambition on a page strongly supports the Sussex Health and Care Strategic Model

Our Local Health & Care - Products

Developing our system capability for population health management, risk stratification, evidence, research, change evaluation and learning

Our Population Insight

Our Connected Care

Our Personalised Care
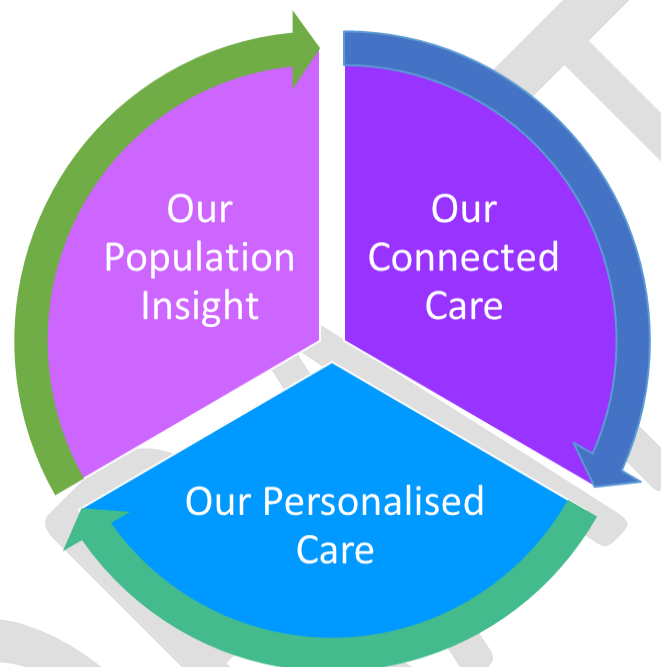
Delivering on the promise of information sharing and enabling communication for the individuals and teams involved in direct care with our population.

Delivering personalised digital health and care services which empower people in self-managing and self-monitoring health and care, enable shared decision making, communication with practitioners, record results and activity and access appropriate care pathways

Figure 67: Key to delivery of the ambition is the development of the three core products for our local health and care

Page 146 of 185

9.1.6. Digital roadmap

Our local health and care products are supported by developing the digital maturity of our organisations and their workforce, to be able to act as strong partners in the development of our Sussex Model of Care. Our ambitions and local health and care products are delivered through our digital roadmap which lays out the expected timelines for achieving our commitments.
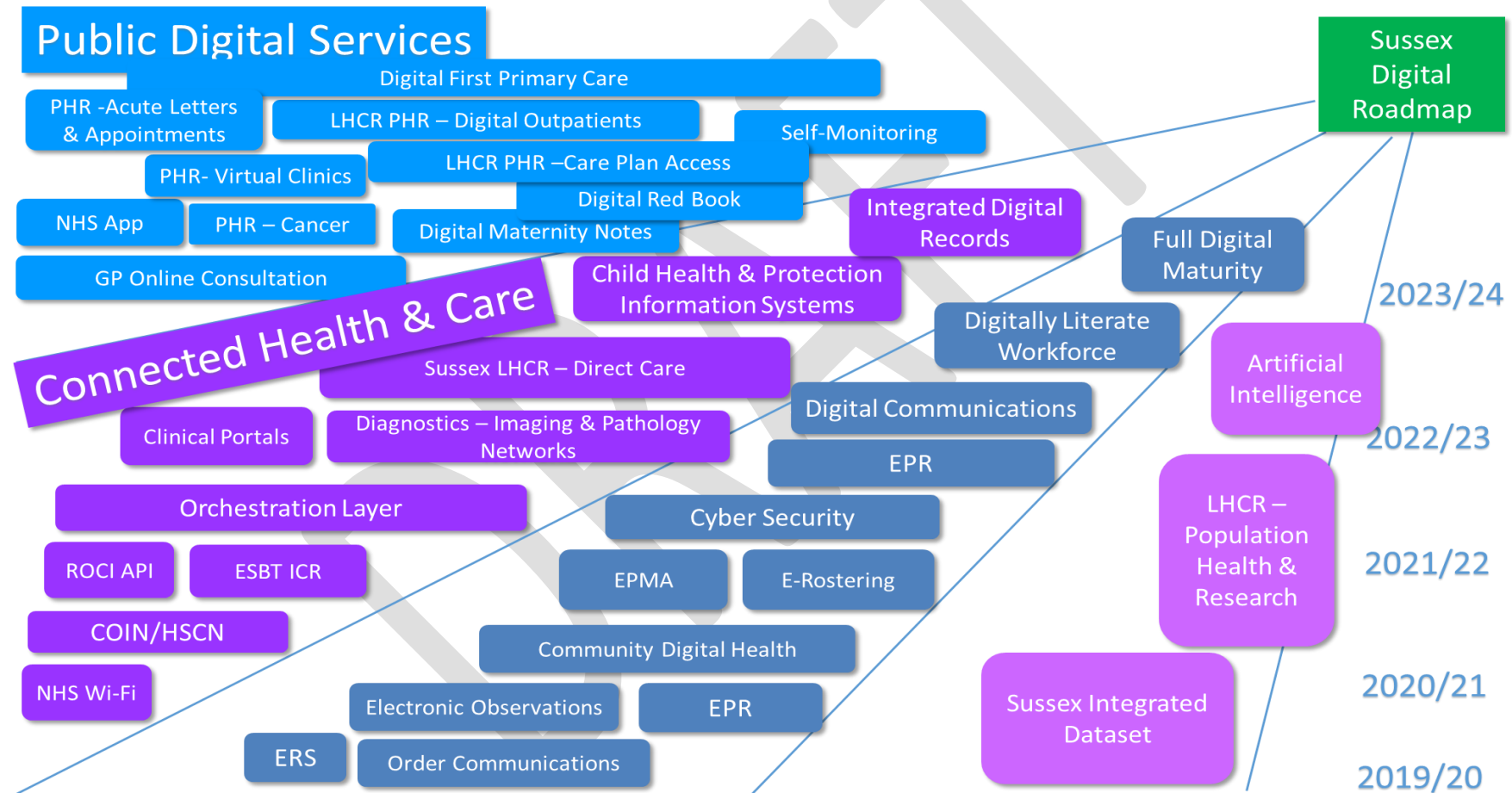

Figure 68: Our digital roadmap

9.1.7. **Our Providers' Digital Maturity**

Our overall ambition is that all partners support each other in growing their individual and collective digital maturity, recognising that, where we let partners lag behind, it harms our collective ability to operate effectively as a digitally-connected system. Partners take responsibility both individually and as part of the wider Sussex system, building upon their strengths and capabilities and sharing the learning to develop blueprints and playbooks for success. Common to providers across all sectors is the collective and individual recognition of the importance of maintaining and continuously improving cyber security postures. Targeted investment is underway to deliver compliance, and to ensure and assure that our collective and individual estate of devices, technical environments, policies, processes and postures are appropriately safe and secure.

Secondary care

All secondary care providers will have reached full digital maturity in line with the assessment standards by 2024, subject to access to adequate investment levels. Strong progress is already being made in achieving digital maturity across providers and Sussex will continue to work collaboratively in prioritising and targeting investments to level-up digital maturity levels and ensure that all providers can work as strong partners to the system.

The following table and diagram summarise the anticipated maturity trajectory for providers over the Long Term Plan period.

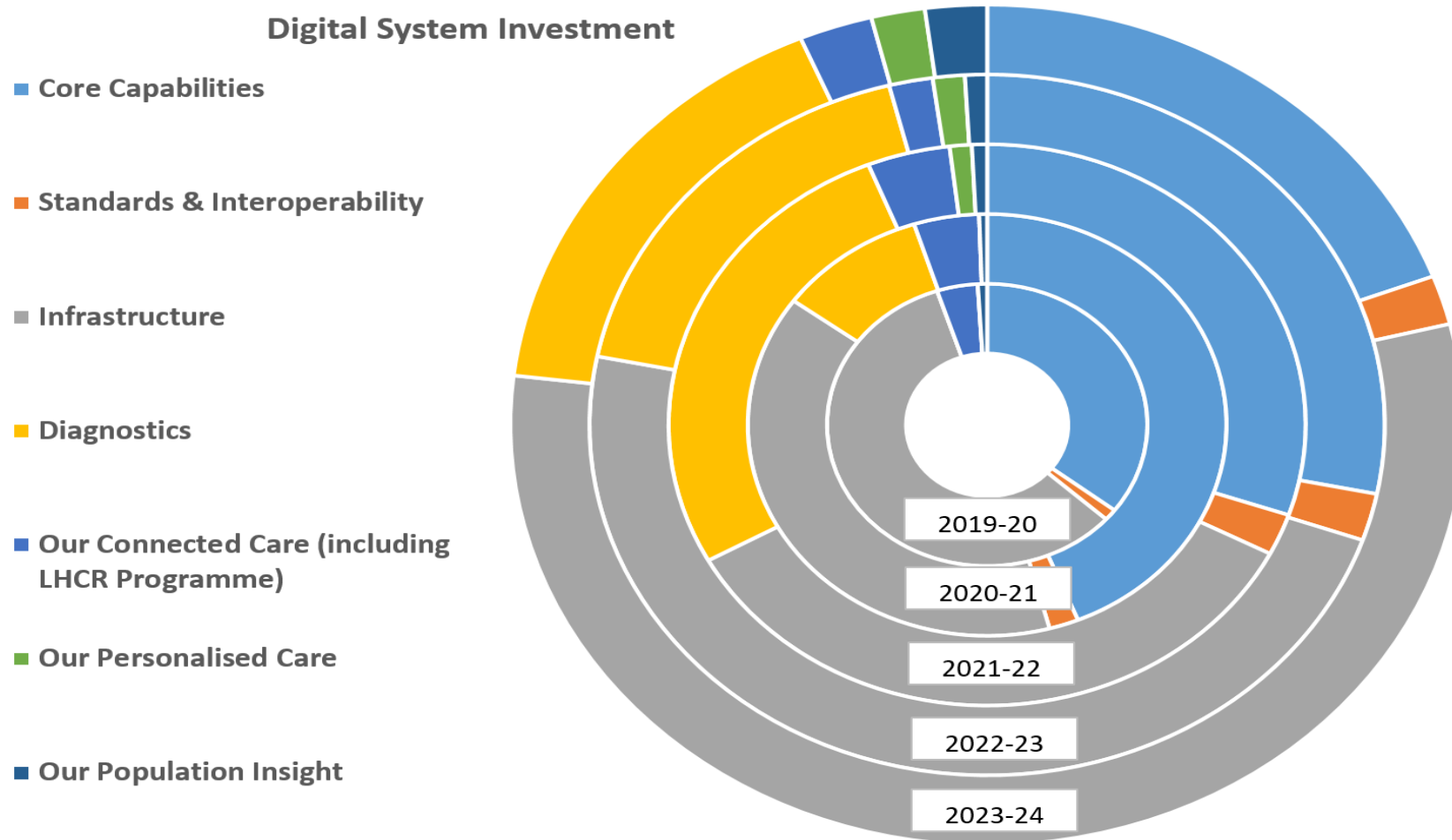| Sussex Digital Maturity Trajectory	2019/20	2020/21	2021/22	2022/23	2023/24
SPFT	🟧	🟧	🟩	🟩	🟩
ESHT	🟧	🟧	🟧	🟧	🟩
SCFT	🟧	🟧	🟧	🟩	🟩
BSUH	🟧	🟧	🟧	🟩	🟩
WSHT	🟧	🟧	🟧	🟧	🟩
QVH	🟧	🟧	🟧	🟧	🟩

Figure 69: Indicative digital system investment profiles. N.B. this also includes investment for Diagnostics maturity which is not included in the LTP commitment of Full Provider Digital Maturity.

£000's	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total
Core Capabilities	£ 7,526	£ 16,286	£ 11,775	£ 9,441	£ 4,603	£ 49,631
Standards & Interoperability	£ 280	£ 742	£ 930	£ 730	£ 452	£ 3,134
Infrastructure	£ 12,404	£ 14,578	£ 13,403	£ 16,023	£ 13,331	£ 69,739
Diagnostics	£ -	£ 3,735	£ 10,500	£ 6,000	£ 4,000	£ 24,235
Our Connected Care (including LHCR Programme)	£ 877	£ 1,637	£ 1,637	£ 595	£ 595	£ 5,341
Our Personalised Care	£ -	£ -	£ 435	£ 435	£ 435	£ 1,305
Our Population Insight	£ 200	£ 200	£ 300	£ 300	£ 500	£ 1,500
						£ 154,885

Figure 70: Indicative digital system investment profiles

SPFT

The Global Digital Exemplar (GDE) Fast Follower programme is underway, with capabilities to be delivered by 2021, followed by a benefits realisation phase to ensure value is delivered more widely. Infrastructure moving to internet and cloud first architecture/O365, as well as significant growth in trust staffing, will drive core investments in the later phase of the plan. The mental health transformation programme enablement includes integrating mental health services into the urgent and emergency care approach, delivering digital therapeutics as part of the Our Personalised Care approach, while working closely with the wider system to ensure mental and physical health integration is enabled through shared records, common communications and linked data for intelligence.

ESHT

Core capabilities and the Electronic Prescribing and Medicines Administration (EPMA) implementation are underway. Significant investment headlines include the Clinical Portal and Evolve Digital Record roll-out, and upgrade or replacement of PAS from 2021. Significant Diagnostic capability improvements will take place over the period of the Long Term Plan, with PACS replacement in 2020 (with Sussex and Surrey partners) and then movement towards Digital Pathology (2021-22), supporting improvements in Cancer Diagnostics performance and enabling new diagnostic workforce and service models across the partners. Artificial Intelligence (AI), Machine Learning (ML) and Genomics capabilities will start to be introduced in later periods from 2023. Infrastructure will see a continuous move to internet and a cloud-first strategy, with O365 starting in 2020. Outpatient transformation has started, using PHR-enabled pathway redesigns initially in Cancer and Diabetes, then working through other priority pathways using virtual clinic models, patient-initiated follow-ups, self-management/self-monitoring and risk stratified pathways.

SCFT

Core TPP EPR is fully deployed, so SCFT are now moving into digital transformation enabled service redesigns and enhancements across services, also enabled by Office 365 and Business Intelligence capabilities and EPMA implementation in 2020. The needs of integrated staff and services working with Primary Care Networks locally is a key driver, with a focus on information sharing under the Our Local Health and Care programme and pathway redesigns including MSK. Significant estates changes at the Brighton General Hospital site, and a projected growth in trust staffing, mean a clear focus on mobility of workforce, using digital services to enable co-designed services with patients and service users, and improving the user experience for staff in delivering services. Service redesigns will incorporate new digital services for referral, self-referral and transfers of care, and deliver patient-facing PHR-enabled services through involvement in system-wide and trust pathway redesigns.

BSUH

EPMA is an immediate priority alongside maternity system replacement following ESHT's initial implementation. Clinical Portal developments support Connected Care LHCR transformations and Transfers of Care. There will be significant diagnostic capability improvements over the period of the Long Term Plan, with PACS replacement in 2020 (with Sussex and Surrey partners), LIMS Replacement through to 2022, and then moves to Digital Pathology (2023-24) supporting improvements in Cancer Diagnostics performance and enabling new diagnostic workforce and service models across the partners. AI, ML and Genomics capabilities start to be introduced in later periods from 2023. Outpatient transformation has started, using PHR-enabled pathway redesigns, initially targeting Opthamology then working through other priority pathways using virtual clinic models, patient-initiated follow-ups, self-management/self-monitoring and risk stratified pathways.

WSHT

PAS replacement is the critical priority starting in 2020. Clinical Portal developments support Connected Care LHCR transformations and Transfers of Care. There will be significant diagnostic capability improvements over the period of the Long Term Plan with PACS replacement in 2020 (with Sussex and Surrey partners), LIMS Replacement through to 2022 and then moves to Digital Pathology (2023-24), supporting improvements in cancer diagnostics performance and enabling new diagnostic workforce and service models across the partners. AI, ML and Genomics capabilities will start to be introduced in later periods from 2023. Outpatient transformation has started, using PHR-enabled pathway redesigns, initially targeting Gastroentorology then working through other priority pathways using virtual clinic models, patient-initiated follow-ups, self-management/self-monitoring and risk stratified pathways.

QVH

e-Observations is the immediate priority for QVH, followed by EPMA in 2020. Significant Diagnostic capability improvements will occur over the period of the Long Term Plan, with PACS replacement in 2020 (with Sussex and Surrey partners), LIMS Replacement through to 2022 and then moves to Digital Pathology (2023-24), supporting improvements in cancer diagnostics performance and enabling new diagnostic workforce and service models across the partners. QVH will continue to develop digital planning and delivery of surgery using CADCAM, VR and 3D printing in maxilo-facial and breast reconstructions.

SeCamb

The immediate priority is the mobilisation of the new 111 and Clinical Assessment services, delivery of core mandated requirements, and integrating with wider systems, including Mental Health and the transformations in the Urgent and Emergency Care system. Key digital enablers of these changes are completing the roll-out of Cleric EPR, and its access by, and then integration with, acute trusts for improvement in handover of conveyed patients to A&E. Medium term improvements will see delivery of a Trust Integration Service to ensure standardised methods of interacting with the developing local LHCRs across Kent, Surrey and Sussex, using nationally and locally mandated standards.

The investment requirements in most trusts are reliant on significant external investment support to achieve full digital maturity within the Long Term Plan period. The system is ready to work closely with NHS England & Improvement and NHS X to agree and shape the investment trajectories in support of the transformation priorities of the Sussex Health and Care Partnership.

9.1.8. **Primary Care**

Digital maturity levels are already reasonable across Primary Care within Sussex and there will be a strong focus on supporting GP Practices and Primary Care Networks (PCNs) to leverage the opportunities to shape their service offers using digital channels and to become Digital First practices and PCNs. This will include harnessing the opportunities provided by the new GP IT Futures programme over the coming years. Key to success in meeting the developing the Digital First offer in primary care will be recognising the challenging capacity demands, expectations of patients and complexity, while looking to the opportunities that new roles and offers in Primary Care Networks such as First Contact Practitioners (FCPs) will require. The Sussex Health and Care Partnership has started on this journey through our early transformation programme approaches across Unwarranted Clinical Variation and Urgent and Emergency Care. Our Local Health and Care programme has agreed MSK as one of its initial clinical priority areas, with the digital needs of staff a critical enabler of the changes being introduced. Sussex has strong experience to learn from in piloting FCP models and will work closely with Accelerator PCNs to understand their user needs and provide targeted digital offers for them. As an example, Physiotherapists and patients in MSK services locally have co-designed and developed a digital offer – MSK Assist, working with national innovation investment and support from the AHSN. Our co-design approach to understanding and then shaping our Digital First offerings, understanding and responding to the needs of patients, practices and pathways will help us evolve our Digital First offerings in primary care based in population needs.

9.1.9. **Infrastructure**

Our providers will take a collaborative approach to infrastructure, ensuring that existing investments deliver their necessary returns while seeking economies within the Sussex system by offering services to other providers or the wider system. At investment renewal points, providers will shift their hosting and infrastructure services towards internet first and public cloud models, using hybrid approaches and taking the learning from each other, while ensuring that they maximise the return on existing investments.

Where new digital services (including the LHCR products) are developed, they are defaulting to internet-first and public cloud offerings, for example the Orchestration Layer and Sussex Integrated Dataset are being hosted within Microsoft Azure. The community will leverage the opportunity in these shared environments and new services to develop its workforce skills, capability and capacity, recognising that there are significant new skillsets required for engineering in these environments, but also acknowledging that adopting common industry standards and approaches will help with recruitment and retention. Primary Care is mirroring this approach for shared and common services, which are defaulting to cloud offerings.

9.1.10. **Skills and culture**

Sussex is developing a strong collaborative Digital Culture, and will work over the coming year with the SHCP Workforce programme, local authorities, Local Enterprise Partnerships and through the Our Local Health and Care programme to develop its leadership and workforce plans. This will include defining and implementing the approach to Digital Leadership, establishing CIO/CCIO roles on the Boards of organisations, and planning for the medium term digital needs of the wider workforce and the specific skills and capabilities required, being mindful of the Topol Review findings and the Interim NHS People Plan. The first phase of this will start in 2020, to baseline the current position and establish the immediate workforce priorities. We will use the lessons we learn

through the 'Our Local Health and Care' programme to help shape the workforce skills approaches and share them widely across the system.

9.1.11. Our Connected Health and Care System

Our Connected Care Products are a key product development in the 'Our Local Health and Care Connected programme'.

Sussex has defined its initial programme of work to improve the interoperability and integration of systems and partners across Sussex through the Our Local Health and Care programme. This will deliver three key product areas in line with the requirements of the Local Health and Care Record requirements. Sussex's approach is to enable clinical priority transformation programmes while delivering exemplar digital services at all geographical levels of our new Sussex Health and Care Strategic Model – neighbourhood, place and system.

The initial clinical priorities identified are MSK and Falls & Fragility, as part of the Unwarranted Clinical Variation programme, and Mental Health, with secondary priorities of Cancer and Diabetes for which we will deliver targeted support. We will work over the first half of the Long Term Plan period to deliver these exemplars and an effective playbook and blueprints for scaling roll-out through the second half of the Long Term Plan period of these services across all clinicians, professionals and communities. We are embedding user-led design approaches into the digital services we will offer and are using the transformation programme to develop the clinical and professional workforce skills, capability and culture to leave a sustainable legacy for continuous quality improvement.

Sussex's Our Connected Care product architecture and technology approach is to build on our existing Beta Orchestration Layer products and local development capabilities and successes, using industry standard public cloud hosted and internet-first architecture in line with national design principles. By building out from existing systems we will minimise disruption for users and can deliver user-led, locally designed and developed products aligned to developing national and industry standards including Care Connect apis and FHIR. This approach has already delivered the Integrated Care Record in East Sussex, bringing together a single user experience launched from users' regular line of business systems – using an initial registry of real-time data apis from GP records, Community, Acute, Mental Health and Social Care to support our developing integrated care teams and their new models of care delivery. The approach is supported by a Sussex-wide approach to information sharing, enabled by the Information Sharing Gateway.
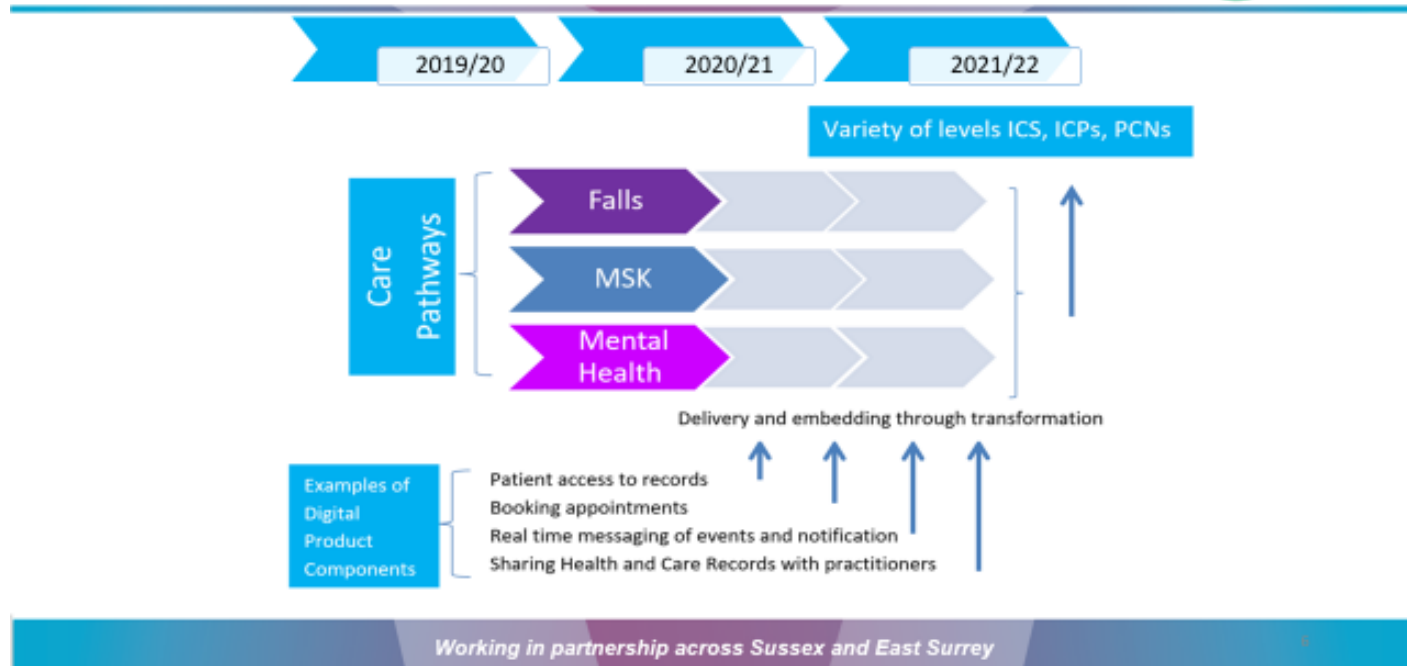
Figure 71: When and where we will deliver

Diagnostics

Our existing Order Communications investments are joining up the order and resulting of diagnostic testing across Sussex, with interoperability across sectors and geographies, which will be fully delivered by the end of 2019/20. Sussex already has a shared diagnostic imaging partnership in place, covering Sussex and Surrey and common, interoperable PACS, RIS and VNA, although not all of the benefits of the original vision have been achieved to date. There is an active re-procurement underway which will see a move to a common cloud-based model, taking advantage of the architectural advances since the previous procurement while ensuring that the standards-based approaches are maintained and enhanced.

There is immediate pressure to ensure that the Diagnostics vision supports the advances in and demands for rapid diagnostics for Cancer services and wider pathways – including adoption and implementation of digital pathology across providers and the links out to genomic testing service remotely. Following the re-procurement and migration, Sussex will use this revived Diagnostic network to seize the opportunities for Artificial Intelligence (AI) and Machine Learning (ML) to support improvements in this area. It is clear from the workforce and emerging demand projections across diagnostics areas that diagnostics could form a supply blocker to clinical and quality improvement if it were to be held back by technology. The implementation of the cross-trust and agile reporting vision will bring together the wider workforce's collective capacity, already embraced in Sussex, and offer the opportunity to further explore AI based automation in reporting.

Page 155 of 185

9.1.12.   Our Digital Services for our Population

Our Personalised Care Products are a key product development in the 'Our Local Health and Care programme'.

We are actively rolling out Personal Health Records (PHRs), supporting the place-based and system-wide outpatient transformation ambitions not just to reduce outpatient appointments by a third, but more importantly to transform the experience of patients in this crucial area, offering digital services which match the raised expectations of patients in our digital age. Initially, this will deliver core functions including access to letters, appointments and results for patients, while providing messaging, care/treatment plan and video consultation options.

Building on our experience developing and delivering successful virtual clinics and digital offerings in fracture clinics, IBD and HIV services, we will enable the digital transformation of the outpatient pathways, including by providing support for the place-based targeted redesigns for gastroenterology and other emerging priorities, and offering virtual clinics, patient-initiated pathways, and self-management and self-monitoring support.

We are already developing the PHR-based Personalised Care Product offerings for risk stratified Cancer follow-ups in Breast, Colorectal and Prostate which, following successful tests in the system, will be expanded to all parts of Sussex over the plan period. We are also enabling the UCV clinical programmes – MSK, Falls, CVD and Diabetes – where we will target digital offerings co-designed with our patients, clinicians and practitioners, ensuring we develop the learning and evidence development. These will work through the whole pathway, from prevention through primary care and into long term condition management, bringing together primary, community, mental health and secondary care provider offerings. Alongside this, we will build on and further develop the work in Mental Health on both Digital Therapeutics and digital service offerings which meet service users' needs and growing expectations. Our strong academic relationships will help us ensure that the evidence-based effectiveness of these approaches is at the heart of our innovation and development. We will deliver across these pathway areas over the first two years and subsequently expand the cohort of patients covered to include new pathways and conditions, ensuring consistent Sussex-wide coverage.

Our ambition is to be able to offer Personalised Care Products to all outpatients and most long term condition patients, recognising that the rapid demographic growth and health economic cost of supporting this population is one of the most critical challenges our Population Health Check identifies. Developing this digital relationship with patients will enable us to better support them in self-managing, self-monitoring and reducing the escalations of care that otherwise develop. We will continue to build our evidence base of approaches that work for cohorts and population groups and enable best possible value to the health economy.

In Primary Care, we will have a Digital First comprehensive offer of online consultations and triage, including video-based consultation, redesigning these to work with the developing new pathways across Urgent and Planned Care. We recognise that GP practices will adopt and develop at different paces due to their local population demand, practice culture and the challenges they are facing. We will support all GP Practices in offering a comprehensive Digital First package for patients, drawing on our initial user-led co-design in East Sussex and the innovation and digital services developed locally across our system. For example, we will develop the already well-regarded social prescribing offers from place and neighbourhoods by supporting them with strong digital offerings. There is an innovative current example in Adur & Worthing, where the digital offer

has been co-designed and developed with the local authority on their low-code platform, using their Same Room user-led design approach to meet the needs of citizens, clinicians and communities.

We recognise the commitment to offer a Digital Primary Care service as a complement to local list-based GP Practice approaches and will work with our local community of GP Practices, Primary Care Networks and the wider system to co-design with our population offers that sustainably deliver quality services for those patients. Given the demand pressures on Primary Care services and the challenge of maintaining the sustainability of GP services for the population, particularly in areas of high deprivation, delivery of Digital First and Digital Only services may provide important opportunities. However, in keeping with our broader approach, we work to understand the user needs of our population and the evidence of the impact and effectiveness of these service models.

9.1.13. Our Data for Population Health and Research

Our Population Insight Products are a key product development in the 'Our Local Health and Care programme'.

We will continue to develop Our Population Insight products including the Sussex Integrated Dataset (our cloud hosted, pseudonymised, linked data platform), to incorporate ever richer and wider datasets. This will provide evaluation and assurance in the development of the Sussex Model of Care, the move to be a self-assuring ICS, and meeting the population health intelligence needs of ICPs and PCN. We will develop targeted offers to help the developing PCN understand in new rich ways the profiles and needs of their neighbourhood populations, and use risk stratification and case finding approaches, drawing on the ever more sophisticated data to predict and identify patients and populations who can benefit from intervention and support. In keeping with our wider approach, we will build on the local learning achieved across Sussex, including the work in Horsham, Mid Sussex & Crawley using population health management and risk stratification approaches to shape their local community understanding and emergent Primary Care Network services for individuals who are approaching end of life; and the work in Brighton & Hove analysing the significant impact on the wider health and care economy of multiple long term conditions in contrast to frailty measures.

We will create the environment for clinical development of new predictive approaches, building on existing strong relationships with Universities (which include SPFT, BSUH, BSMS and Sussex & Brighton Universities and the newly agreed Applied Research Collaborative across Kent Surrey and Sussex, hosted by SPFT). We will also begin to test and evaluate the effectiveness of new clinical and population health AI approaches. For example the national review of AI & ML in Healthcare in the UK written by DHSC and KSS AHSN highlighted the ASTRODEM project, where local academic researchers working in a cross disciplinary team across primary care, astrophysics and data science have developed AI models for early diagnosis of dementia. The SID will offer a new environment to bring research initiatives into real-world practice and enable the longitudinal evaluation of these models in partnership with academic colleagues and the AHSN.

We will work to develop new workforce skills, capabilities and pathways to ensure our analytics, intelligence and data science skillsets are embedded in clinical and professional development, and that we have understood both the opportunities and needs which Professor Topol's review identifies.

AI and ML will also play a crucial role in developing our system-wide approaches to the demands on diagnostic capacity and capability, as the changing demographic profile and advances in

Page 157 of 185

diagnostic requirements place ever greater demand on an already challenged workforce. We will build on our networked imaging and other diagnostic capabilities, following our migration to a new cloud-hosted service, to then start training and applying AI in imaging, testing and understanding the complex clinical pathway and safety redesigns needed to confidently adopt these approaches while maintaining and enhancing quality.

Importantly, we will continue to build on our effective system-wide approach to operational pressures management in Urgent & Emergency Care using the SHREWD service. This approach to using clear common, visualisations of agreed up-to-date data to improve real-time system decision making has proven effective. We will move on to examine how we can start to incorporate, evaluate and operationalise projection and predictive measures into this area, drawn both from existing health and care data patterns, but also considering how wider measures may effect things from weather projection to emerging social intelligence, for example in flu outbreaks.

9.1.14. Sussex system digital investments

Sussex Digital Investment Profile		Year 1		Year 2		Year 3		Year 4		Year 5		Total	
		C	R	C	R	C	R	C	R	C	R		
	Digital Investment	2019-2020	2019-2020	2020-2021	2020-2021	2021-2022	2021-2022	2022-2023	2022-2023	2023-2024	2023-2024	C	R
SPFT	Core Capabilities	1468	430	988	540	485	540	485	540	485	540	£3,911	£2,530
	Standards & Interoperability	105	0	222	0	275	50	175	50	97	50	£874	£150
	Infrastructure	3169	250	3758	250	2663	250	5663	250	2891	250	£18,144	£1,250
ESHT	Core Capabilities	1468	30	2655	440	1360	290	1720	40	260	40	£7,463	£840
	Standards & Interoperability		100	200	100	330	100	230	100	30	100	£790	£500
	Infrastructure	1585		2420		2690		2610		1690		£10,995	
	Diagnostics			1060		1000						£2,060	
SCFT	Core Capabilities	1400		2448	481	2500	210	2500	210	2283	210	£11,131	£1,111
	Standards & Interoperability	75		120		150		150		150		£645	£0

	Infrastructure	1400		2100		1300		1500		2500		**£8,800**	
BSUH	**Core Capabilities**	2000		2367		800		450		250		**£5,867**	**£0**
	Standards & Interoperability											**£0**	**£0**
	Infrastructure	3000		3000		3000		3000		3000		**£15,000**	
	Diagnostics			1300		4500		3000		2000		**£10,800**	
WSHT	**Core Capabilities**	100		3642		3675		2971		150		**£10,538**	**£0**
	Standards & Interoperability											**£0**	**£0**
	Infrastructure	3000		3000		3000		3000		3000		**£15,000**	
	Diagnostics			1300		4500		3000		2000		**£10,800**	
QVH	**Core Capabilities**	260	370	725	435	760		200		100		**£2,045**	**£805**
	Standards & Interoperability											**£0**	**£0**
	Infrastructure			50		500						**£550**	
	Diagnostics			75		500						**£575**	
SeCamb	**Core Capabilities**			1565		1155		325		285		**£3,330**	
	Standards &			100		25		25		25		**£175**	

174

Sussex System													
	Interoperability												
Sussex System	**Our Connected Care (including LHCR Programme)**		877		1637		1637		595		595		£5,341
	Our Personalised Care						435		435		435	£0	£1,305
	Our Population Insight		200		200		300		300		500	£0	£1,500
Total		19030	2257	33095	4083	35168	3812	31004	2520	21196	2720	£139,493	£15,332

Figure 72: Our digital investments

9.2. Estates

9.2.1. Current overview

The system partnership has worked collaboratively to ensure that the Estates Strategy responds to and supports the need of the local population and the Sussex Health and Care Plan.

The initial Sussex and East Surrey STP Estates Strategy was developed in July 2018. This was assessed by NHS England and Improvement (NHSE/I) and given an overall banding of "improving". Significant progress has been made to further develop and deliver the Estates Strategy and this has been reflected in the Sussex and East Surrey STP Estates Strategy Checkpoint document, which was submitted in mid July 2019. A summary of investments and capital priorities can be found in Appendix H.

The Checkpoint submission includes detailed updates on:

- 2018 Estates Strategy Feedback and system response
- Estates governance
- Clinical service strategies and capital plans
- Primary care estates strategies and capital plans
- Disposal plans for surplus land and buildings
- Estates efficiencies
- Delivery of STP Wave 1-4 capital projects
- Delivery plan
- All capital projects across the system.

Re-assessment of this document by NHSE/I is complete. We have been advised that a recommendation for re-banding of the Estates Strategy from "improving" to "good" has been made to the NHS Property Board. A formal outcome is anticipated in November.

This re-banding is a prerequisite for the approval of all STP Wave 3 and 4 capital business cases.

9.2.2. Estates priority delivery areas

The Estates Strategy has been developed around two key themes. Each theme includes a set of strategic objectives which are aligned to national and local priorities within the Five Year Forward View, the Long Term Plan and the Sussex Health and Care Plan:

1. Transforming models of care

   - Out of hospital care including One Public Estate
   - Urgent and emergency care services
   - Mental health case for change
   - Construction of the BSUH 3T's
   - Clinical service development and modernisation

2. Keeping the estate safe and fit for purpose

   - Reduce high and significant backlog maintenance
   - Make the estate more efficient
   - Shared services

Transforming Models of Care

Page 162 of 185

Out of hospital care

Primary care services will be delivered at scale with co-location and cooperation of practices within Primary Care Networks. The primary and community estate will be planned and managed to support the development of integrated community hubs. These hubs will deliver primary, community, mental health and out of hospital services, catering for the health and care needs of the local populations. Where possible, services will be expanded to include community-based maternity hubs, rapid diagnostics for cancer, and health, wellbeing and prevention services.

The total investment requirement to deliver this vision is circa £373 million. This includes a comprehensive configuration of area and local health hubs supported by primary care spokes across Sussex. The list of anticipated integrated hubs and primary care spokes is included within the Estates Strategy Checkpoint document in section 4.

Work is ongoing to develop the Primary Care Estates Strategy in response to the Primary Care Strategy. Detailed analysis of existing primary care infrastructure, including condition, functionality and capacity, has been undertaken. Further work is in development to understand the impact of multi-morbidity at PCN level, population and housing growth, demographics, deprivation, and social care need. It is anticipated that this strategy will be complete in early 2020.

Urgent and emergency care

The investment requirement to deliver the estates element of the Urgent and Emergency Care Programme is circa £48 million. This includes the delivery of urgent treatment centres, co-located with the acute provider emergency departments, minor injury units and extended access hubs; new diagnostic equipment including MRI scanners; and the development of "make ready centres" for the ambulance service. The two "make ready centres" have secured DH FBC approval as part of the STP Wave 4 capital bidding process and construction is due to commence shortly.

Funding is required to deliver plans for the UTC's at Worthing, Eastbourne and Conquest hospitals, having been unsuccessful in the previous STP capital bidding round.

Mental health case for change

Specialist inpatient centres to transform the delivery of adult acute and dementia care are in development in West and East Sussex. A complex transformation programme is underway which includes the relocation, reconfiguration, replacement and disposal of unfit/surplus estate, and the co-location of community mental health services into integrated community hubs. Public consultation is required in relation to significant service change.

There is an investment requirement of circa £130 million to deliver this transformation programme. Part of this investment will be funded from within the providers' capital resource limit and part from their disposals programme. There is likely to be a funding shortfall.

Construction of the BSUH 3T's

The Teaching, Trauma and Tertiary care (3Ts) programme is a £485 million redevelopment of the Royal Sussex County Hospital, scheduled for completion in 2024/25. Funded from public capital supported by a Treasury approved FBC, the programme will be delivered in three phases over nine years and will replace 50% of the trust's ageing estate on the Royal Sussex County Hospital in two new buildings accommodating more than forty wards and departments. The new accommodation will provide the highest standards of clinical functionality and patient environment. This programme supports the accelerated transformation of old estate to meet the demands of the modern health service.

In addition to the £485m project costs, the FBC assumed a further £26 million funding from alternative sources. This funding has now been secured following extensive discussions with NHSE/I.

Clinical service development and modernisation

There are several significant clinical service development schemes requiring investment funding to deliver the estates solution. Providers are working collaboratively to meet the national requirement for all pathology services in England to be part of a pathology network by 2021. The system has secured STP Wave 3 capital funding of £19.3 million, subject to approval of business cases, to support the integration of pathology services across three provider trusts.

In terms of estates modernisation, the system has a high level of critical backlog maintenance and compliance issues. This has resulted from a historic lack of investment over many years by previous system leaders. There is a requirement for fire compartmentation works at Eastbourne hospital to meet statutory fire regulations, and the value of these works is circa £13.9 million. A bid for STP Wave 4 capital was unsuccessful and a further bid was submitted to NHSE/I for emergency backlog maintenance funding, which has very recently been approved.

The total investment requirement for this strategic objective is circa £155 million.

Keeping the estate safe and fit for purpose

This aim includes reducing the high and significant backlog maintenance, making the estate more efficient and managing shared services.

Provider trusts are working collaboratively to deliver operational estates efficiencies to meet the national Carter targets. These targets include efficiencies around estates running costs, percentage of non-clinical space, unoccupied floor space, total backlog maintenance and critical infrastructure risk backlog maintenance.

In terms of estate running costs the system performs well against national benchmarks. The provider trust median is £35.46 per sqm less than the national benchmark and the number of estates running costs has reduced from July 2018. Providers are planning to reduce this further by 2020/21.

There is a requirement within the LTP for all providers to reduce their amounts of non-clinical space by a further 5%, freeing up over one million square metres of space for clinical or other activity. As indicated in the table below, the providers have reduced the percentage of non-clinical space to 24%, which is 11% below the Carter target of 35%. Whilst this reduction is significantly smaller than the national benchmark, providers will continue to work to reduce this percentage further.,

Total backlog maintenance and critical infrastructure risk is likely to increase during 2019/20 as the outputs from six facet surveys carried out at ESHT and BSUH are realised. Western Sussex Hospitals has commenced a trust-wide programme to significantly reduce backlog maintenance and critical infrastructure risk over the next five years and a similar approach may need to be adopted by other providers.

The total investment requirement for these three strategic objectives is circa £62.9 million, with £56.4 million allocated to delivering high and significant backlog maintenance projects across the system.

Page 164 of 185

A detailed summary of progress against the estate efficiency targets is set out in the following table.

Indicator	Baseline 2017/2018 position	Forecast target position for 2020/2021 (17/18 prices)	Progress against targets
Estate Running Costs pa Estate Running Costs £/m2 (median)	£205.9 m £324.54	£202.5 m £315.00	Benchmarked against NHSI Carter/ERIC 2017/18 E&F data analysis of £360 per m2 – Trust median is £35.46 per m2 less than national benchmark Reduction in total estates running costs from July 2018 Strategy of £21.87 per m2 and £23.4m per annum
Non-Clinical Space m^2 Non-Clinical Space % (Carter target 35%)	190,425 24%	220,134 24%	Benchmarked against NHSI Carter/ERIC 2017/18 E&F data analysis of 33.9% for non clinical space – Trust median is £9.9% less than national benchmark Reduction in non clinical space from July 2018 Strategy of 5.2% To note: ESHT: 6 facet survey due in July 2019, significant increase predicted.
Unoccupied Floor Space m^2 Unoccupied Floor Space % (Carter target 2.5%)	17,165 2.3%	14,918 1.6%	Reduction in unoccupied floor space from July 2018 Strategy of 0.7% SFT: Service improvements are expected to increase the use of clinical space
Total Backlog maintenance (£)	£146.7 m	£148.1 m	ESHT: 6 facet survey due in July 2019, significant increase predicted and unlikely to reduce without significant external capex investment. WSFT: A corporate project has commenced with a commitment to significantly reduce backlog and critical infrastructure risk over the next 5 years.
Critical Infrastructure Risk (CIR) Backlog Maintenance (£)	£59.2 m	£72.9 m	BSUH: 6 facet survey being undertaken. SASH: Complete review underway.

Figure 73: Progress against estates efficiency targets

9.2.3. Sustainability

Providers are working collaboratively to progress energy efficiency and environmental sustainability initiatives across the estate. Specific projects include:

- **System-wide EPC project:** Procurement of new energy infrastructure and services for six of the Sussex and East Surrey providers through an ESCo arrangement delivered through the Carbon and Energy Fund Framework. Net savings of £15.7 million over 15 years have been identified alongside significant reductions in carbon emissions. The invitation to tender is in the process of being released to the shortlisted bidders following a series of technical meetings over the last few months. Construction is due to begin in March-May 2020.

- **Joint waste tender:** Delivered across four trusts for healthcare and non-healthcare waste. The project will deliver financial savings (level still to be determined) and waste targets across the trusts to meet zero waste to landfill and 75% recycling targets.

- **Care Without Carbon SDMP**: Integrated across four trusts, delivering savings and carbon reductions in line with the Climate Change Act and NHS Long Term Plan.

9.2.4. Prioritised capital programme

The capital programme included with the Estates Strategy Checkpoint document includes all investment projects for Sussex and East Surrey. East Surrey has since transferred to the Surrey STP/ICS and this has necessitated a refresh of the capital programme and prioritisation process.

The programme has been further developed, assessed and prioritised by key stakeholders from across all Sussex NHS organisations. It reflects the ambitions of the system to deliver the key priorities within the Sussex Health and Care Plan.

The programme has been divided into two sections:

- Section one includes all system strategic investment projects in priority order, regardless of funding, total value £742 million (all projects over £500,000 value)
- Section two includes those system strategic investments that require capital funding (PDC), in priority order, total value £345 million.

A schedule of the updated Sussex prioritised system strategic investment projects and prioritised capital projects can be found in Appendix H.

A summary of the 21 system-wide schemes prioritised for capital expenditure is set out in the table below:

Strategic Ranking	Capital Ranking	Project Title	Organisation	Project Value (£000's)	Delivery Year
4	1	Eastbourne UTC	ESHT	3,800	21/22
5	2	Conquest UTC – Development of Single Assessment Unit	ESHT	6,500	21/22
6	3	Worthing UTC	WSFT	13,200	21/22
8	4	Crawley Hospital	Crawley CCG	125,000	23/24
9	5	Littlehampton Primary and Community Hub	CWS CCG	15,000	23/24
10	6	East Sussex Bed Reconfiguration	SPFT	70,000	23/24
12	7	Acute reconfiguration to enable SPFT bed reconfiguration	ESHT	1,500	23/24
16	8	Shoreham Integrated Community Hub	CWS CCG	6,000	22/23
19	9	Horsham Community Hospital	HMS CCG	25,000	23/24
23	10	Worthing Critical Care - right sizing project	WSFT	5,800	20/21
24	11	Bognor Health Centre redevelopment	CWS CCG	15,000	24/25
26	12	Maternity Configuration	ESHT	8,000	24/25
29	13	Lancing health centre	CWS CCG	7,000	24/25
31	14	MRI	QVH	1,635	20/21
32	15	Crawley Hospital Child Development Centre	Crawley CCG	3,800	20/21
33	16	Medical Day case unit at Conquest	ESHT	2,750	20/21
52	17	North Horsham Holbrook	HMS CCG	1,000	20/21
59	18	Day case unit at EDGH	ESHT	8,000	21/22
62	19	Ophthalmology: service modernisation/relocation	ESHT	8,013	21/22
66	20	Non-clinical space rationalisation	ESHT	1,500	21/22
68	21	EDGH Residential enabling scheme	ESHT	16,675	24/25

Figure 74: System-wide schemes prioritised for capital expenditure

Page 166 of 185

Delivery of STP capital projects

The Sussex Health and Care Partnership has four approved STP capital schemes - the Wave 3 Pathology Centralisation project and three Wave 4 ambulance projects. Whilst the system submitted nine urgent projects (excluding the ambulance projects) for Wave 4 funding to support delivery of the key strategic objectives, these were unsuccessful. The total cost of these projects was £391.9 million, of which £77.2 million was sought for funding from Wave 4.

Of the four successful schemes, two have now received DH business case approval and construction has started on site.

An overview of these schemes is set out in the table below:

Lead Organisation	Title of Scheme	Scheme Description	Total STP Capital Funding (£,000)	FBC Approval
South East Coast Ambulance Service NHS Foundation Trust (SECAmb)	Worthing Make Ready Centre (MRC)	Centralisation of staff and expansion of the Make Ready facilities at Worthing MRC	235	approved
South East Coast Ambulance Service NHS Foundation Trust (SECAmb)	Brighton Make Ready Centre (MRC)	Centralisation of staff and expansion of the Make Ready facilities at Brighton MRC	5,520	approved
South East Coast Ambulance Service NHS Foundation Trust (SECAmb)	Expansion of additional floor space at the Trust Headquarters building	Acquisition of the second and third floors, Nexus House, via an operating lease and capital costs for the development of the site to make it operational	6,710	01/11/2019
Surrey and Sussex Healthcare NHS Trust	Clinical pathology hub	Centralisation of pathology services between three acute trusts as second stage of implementation of Pathology Network 7 consolidation plan	19,334	31/12/19

Figure 75: Four approved STP Capital schemes

9.2.5. **Disposals**

Page 167 of 185

The Sussex Health and Care Partnership has developed a system-wide disposal plan to support the identification and disposal of surplus land and estate. Progress is actively managed at the monthly Estates Programme Board.

The value of disposals identified by the system exceeds the national "Naylor Fair Shares" disposal target of £75.7m by £37.97m. The system has identified 1,222 housing units against the "Naylor target" of 1164. This demonstrates an additional 58 housing units above the Naylor target. This figure is conservative and likely to increase once disposals have come to fruition.

In the past 12-month period, 11 sites have been sold and two sites removed from the plan (one was out of area and one has been withdrawn). Six further sites have been added.

The summary disposal programme is set out in the table below.

| Number of Disposals	Land Area – hectares	Estimated Sale Receipt	Estimated Housing Numbers
44	21.93	£113.67 million	1,222

9.2.6. **Governance and programme management**

The Estates Programme is embedded within the Sussex Health and Care Partnership governance structure, and the Estates Programme Board reports monthly to the Portfolio Management Board on delivery, finance, and milestones, while highlighting any risks associated with achieving benefits and outcomes. There are highlight reports for the major projects and the key strategic themes. The Programme also updates the STP Finance Group on progress.

As the ICS develops, the Estates Programme will become more dynamically aligned to the new integrated care hubs and PCNs. Estates will work closely with Digital and Workforce plans as an enabler to the development and expansion of integrated care networks, with the provision of buildings as platforms to support physical and virtual co-located working for multiple agencies; at the same time, improving public access and facilitating end-to-end patient journeys.

The Estates Programme Board will oversee assurance within the Estates Programme to ensure that it is both properly aligned to other workstreams and delivering on what is needed for the ICS to take shape.

9.2.7. **Delivery plan**

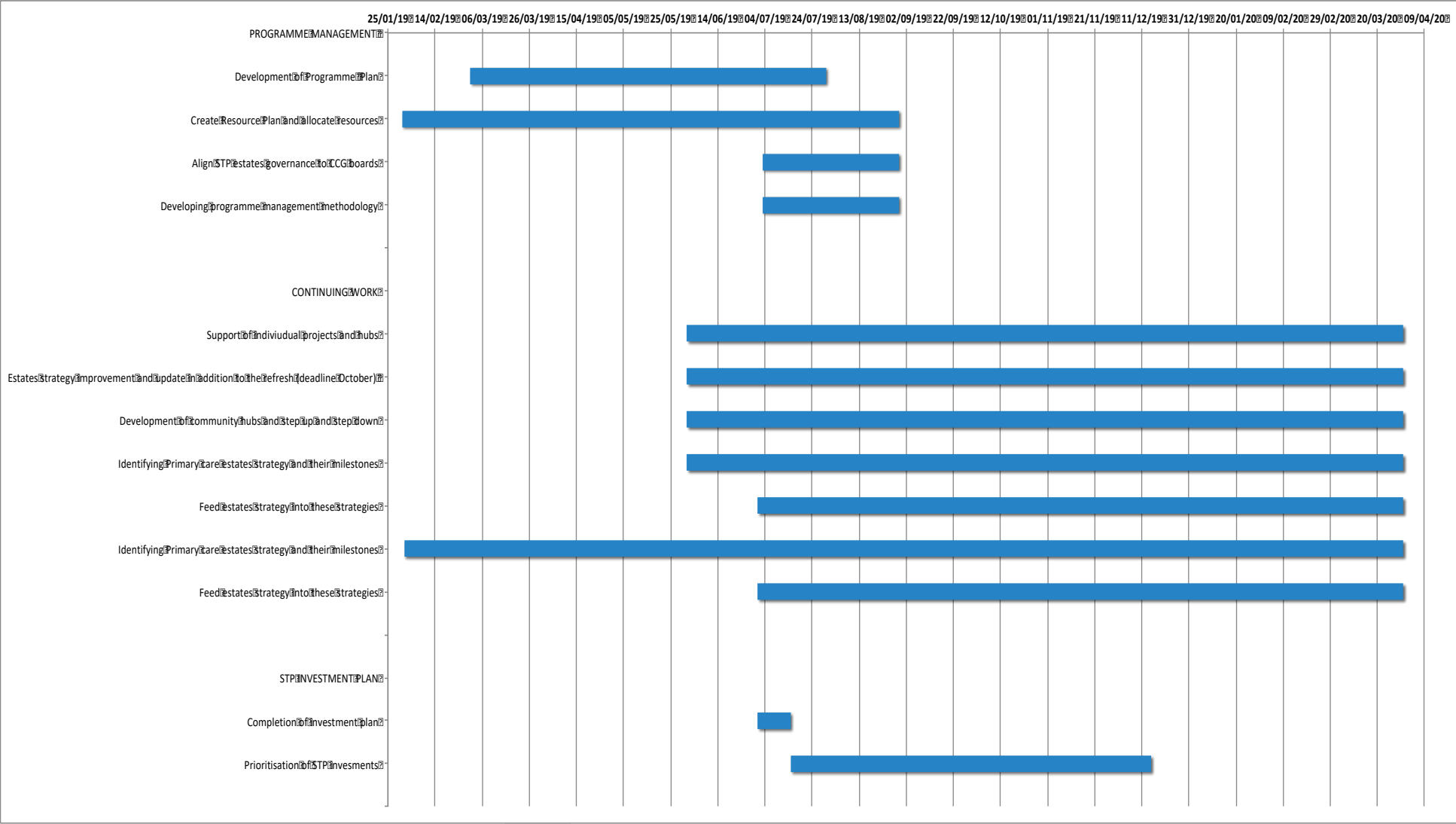The summary delivery plan is set out below across the two tables:

Working in partnership across Sussex
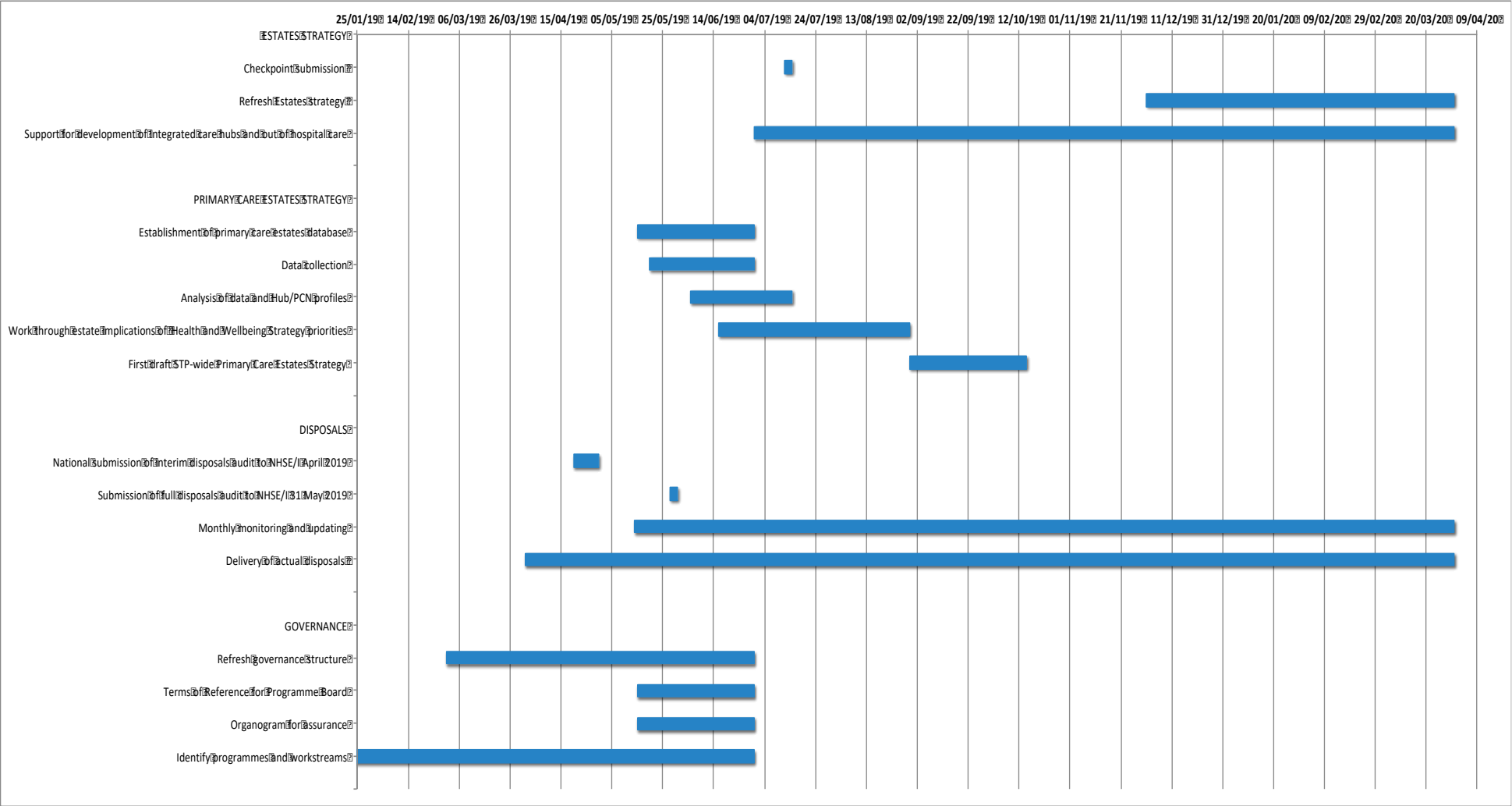
Figure 76: Summary Delivery Plan

Working in partnership across Sussex

10. Programme governance

10.1. Governance and monitoring delivery

There are many change programmes working across the Sussex Health and Care Partnership portfolio as shown below.

- Theatre efficiency
- Cancer Alliance
- Outpatient development
- ICP development
- ICS accelerator
- CCG transition
- Personalisation of care
- Head and neck
- Diabetes
- Dermatology
- Mental health
- CEC/POLCE

- Back office
- CHC
- Step Up Step Down (Community responsiveness)
- Urgent and emergency care
- Estates
- Digital
- Workforce
- Maternity
- Unwarranted Clinical Variation (MSK, CVD and Falls & Fragility)
- Medication management
- Procurement

An overall Programme Director and Programme Management Office (PMO) is in place to maintain oversight and control of these programmes. The monthly portfolio review process ensures there is high quality planning and delivery from the individual workstreams, and a less formal weekly meeting allows the Programme Leads time to manage the interdependencies between the schemes and design universal communications for all stakeholders.

There are senior leads for each of the programmes and some also have clinical leads. It is recognised that there is a very wide range of programmes and so the portfolio is currently being reviewed to ensure that the leadership, governance, support and delivery outcomes are robust. This will align the current local programmes to LTP requirements, for instance Stroke and Ageing Well, and streamline the delivery approach.

The review of portfolio governance is due to be completed in November 2019 and at that stage programme reporting and support is likely to change. In advance of these changes, the principles by which the portfolio is governed have been agreed by the Partnership Executive:

- The portfolio of programmes will support collaborative working by the way the programmes are set up and delivered.

- Partners maintain control of the transformational changes, can be assured of delivery, but with appropriate level of detail. The Partnership Executive group will not be the Programme Board, but will have visibility to be assured of programme developments.

- Each programme will have a Board, with a Programme Lead, SRO and Executive Sponsor. Each Programme Board will be self-managing and capable of delivering its agreed outcomes and escalating when necessary.

- Each programme will report into one of the Partnership Groups, to ensure alignment between similar programmes, agree scope, timescales and outcomes for the programme, and provide the point of escalation for programme issues.

- All programmes will be coordinated and supported through a Portfolio Management Group to manage the interdependencies, risk, communications, finance and escalation of issues.

- Programmes to do with clinical pathways and practice will be led by providers. Programmes to do with system structures will be led by commissioners. All programme boards will have a collaborative approach with commissioners and providers.

- There will be a universal offering of administration and programme management support for all agreed programmes of work.

- All programmes will report at least monthly.

The governance of the delivery programmes will also be reviewed to ensure that the Clinical and Professional Cabinet has a stronger role in setting and assuring meaningful outcomes to enable outcomes-based commissioning.

10.2.   Quality and assurance

Within Sussex, the Quality and Safeguarding directorate works in partnership with providers and partners to drive up the quality of services for our population. As we undertake this wide scale system reform, it becomes even more important to ensure we continue to provide services of the highest quality, delivered with respect and compassion, and a positive experience for our population.

As we mature towards becoming an ICS over the next six months, we are reviewing our other system-wide governance including the groups overseeing strategy and the groups overseeing operational delivery to ensure clear direction for, and delivery of, our priorities. We propose also to develop a Quality and Performance Improvement Group to take collective oversight of problem solving for escalated concerns and sharing best practice.

Integrated assurance will take place at each level, retaining a clear line of sight for system, local place and individual organisational performance, with ability to report at each level if required. For more information, please see our 'Quality and Assurance Improvement Framework' developed in collaboration with CCGs and NHS England and implemented from 1 April 2019.

10.2.1.   Quality and safety improvement for all services including non-NHS providers

Through our continuous quality improvement programme, working closely with providers of health and care we will continue to drive for outstanding care in the NHS services we directly commission and in the independent, non-NHS and care sectors. This will include the following providers of health and care:

- NHS trusts
- Community providers
- Independent providers
- Care and nursing homes
- Primary and community care providers

Our continued aim will be to strive for excellence through effective commissioning of high quality services that reduce avoidable harm and create the best environment for patients. This will be in line with meeting the requirements of the NHS constitutional standards, the Long Term Plan, the Interim People Plan and our local Patient Safety Strategy. We will have a particular focus on areas

Page 172 of 185

identified by our early warning system where standards are falling below par, such as Referral to Treatment and Cancer Waiting Times. This will be achieved by continuing to work together with provider clinical teams, Continuing Healthcare, and commissioning teams from health and care, whilst embedding our good practice approach to reviewing and learning from clinical harms.

Our overall approach consists of the following elements:

- Ensuring risks are assessed, recorded and reviewed as part of our corporate risk registers
- Applying a systematic, well-governed approach to implementing high quality cost effective sustainable improvements using our established quality assurance and improvement framework
- Working in partnership with local authorities, patients, their families and carers to design and redesign services that meet their needs and deliver improvements to care and support
- Applying a rigorous approach to quality improvement measures, with a focus on improving outcomes for people, reducing health inequalities, and holding providers to account for the delivery of high quality safe care
- Effectively engaging system partners both from within the organisations and externally by regularly communicating our progress
- Fostering a culture of celebrating successes and collectively learning how to improve.

10.2.2. Patient safety

The Sussex Partnership aims to deliver effective leadership at all levels to embed a patient safety culture in line with our robust patient safety system. Our approach will be fully aligned with the NHS Patient Safety Strategy's three strategic aims to:

Insight	Improve understanding of safety by drawing intelligence from multiple sources of patient safety information
Involvement	Equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system
Improvement	Design and support programmes that deliver effective and sustainable change in the most important areas

Figure 77: Our approach to patient safety

The Sussex patient safety approach consists of the following elements which we will constantly refine through our learnings from partnership working across our local system:

- Set and closely monitor agreed patient safety measures with all providers (commissioned and non-commissioned services)
- Identify, investigate, report and learn from incidents through strong, effective, well-governed mechanisms
- Ensure our Safety Scrutiny Panels and Quality Committees are well-led and enabled to recommend/assure Governing Bodies
- Identify and respond to themes and trends for improvement as part of our established quality assurance and improvement framework, and use these to inform our system priorities for continuous quality improvement
- Ensure that delivery of our approach to learning from all deaths/preventing future deaths is systematic and robust, with learning enabled system-wide

Page 173 of 185

- Agree specific recovery plans and improvement interventions jointly with commissioning teams and providers, holding providers to account for timely delivery
- Facilitate local learning events to celebrate learning together
- In line with Duty of Candour, adopt an open, transparent approach involving patients, their families and carers in all aspects of serious incidents.

10.2.3. Managing provider performance

Our aim is to continue to work jointly with our providers of health and care, building on our proven track record to improve the care they deliver. Through our recognised quality improvement work, we are committed to building upon current progress to ensure that:

- Our organisations sustain their 'outstanding' statuses awarded by the Care Quality Commission
- We support those awarded 'good' to aspire to the delivery of outstanding care
- For those currently rated as 'requires improvement', we support individual recovery plans to target quality improvement

In the event that we have a poorly performing provider, we would establish an improvement plan in collaboration with the provider, typically consisting of the following elements:

- Workforce
- Meeting the needs of people with deteriorating physical and psychological health
- Care planning, including personalisation and management of clinical risk
- Managing clinical conditions and presentations
- Local quality assurance and improvement monitoring
- Engagement and experience of people we support
- Safeguarding
- Communication and enhancing the well-led ethos.

10.2.4. Ensuring quality and safeguarding

All commissioning plans will be assessed for their impact on quality for patients, including impacts on equality and health inequality. In 2018/19, a revised Quality Impact Assessment Policy for Sussex and East Surrey was introduced. This has been revised to incorporate equality and health inequalities impact assessments in line with the LTP and our local priorities. We also measure quality using CCG Quality Assurance and Improvement frameworks to provide a structured approach to escalating quality concerns using a risk-based methodology. This will enable the commissioning quality team to proactively safeguard people, using a consistent evidence-based approach. Interventions to improve care delivery will be coordinated and delivered collaboratively across all system partners.

The Quality and Safeguarding directorate will work alongside our commissioning teams to:

- Monitor the performance of providers against agreed quality standards and outcomes using all contractually-reported indicators relating to patient experience, patient safety (including safeguarding) and clinical effectiveness
- Ensure that there are processes and procedures in place with providers to evaluate and mitigate the impact for patients where constitutional standards are not being met
- Carry out surveillance in line with the Care Quality Commission 'domains' (safety, effectiveness, patient experience, leadership, culture and responsiveness)

Page 174 of 185

- Use the Commissioning for Quality and Innovation (CQUIN) payment framework to support local improvement.
- Undertake quality assurance visits to services where quality concerns have been identified.

10.2.5. **Our quality and safety priorities**

In delivering on all of the commitments within the Long Term Plan, we will continue our journey of continuous quality assurance and improvement against our quality and safety priorities across Sussex. This includes:
- Commissioning services in line with national quality standards and local clinical priorities
- Aiming for 'harm free care' – pursuing a patient safety culture of continuous learning and quality improvement, effectively managing serious incidents and assessing the level of risk and action required, ensuring system-wide trends are identified for improvement and system-wide learning is embedded
- Safeguarding vulnerable populations and protecting adults and children from harm in partnership with our local authorities
- Developing a capable, confident competent workforce to deliver high quality safe care
- Learning from our patients – complaints, feedback, and surveys will continue to be important sources for measuring our progress and determining whether we are meeting local populations' needs.

Although we have identified these as Sussex-wide priorities for the Quality and Safeguarding directorate, quality assurance is integral to our whole strategy. Therefore, for more information on addressing quality in primary care, please see section 4.3 on primary care networks, and how they will drive improved health outcomes through greater investment, enhanced community partnerships, greater collaboration and more multidisciplinary working. Similarly, within urgent and emergency care, we are improving standards through programmes to reduce pressure on A&E, implement UTCs, improve discharges and reduce DTOCs, all of which are explained in section 7.1.2.

Learning from serious incidents

Sussex will continue to support its CCGs to fulfil their statutory responsibilities for management of serious incidents reported by commissioned services. There is a patient safety team based at Brighton & Hove CCG who provide oversight and effective management of serious incidents for all providers across Sussex. All serious incident investigations will be reviewed at a fortnightly Serious Incident Scrutiny Group.

The CCG will seek assurance that lessons learned and action plans have been embedded in practice at contractual quality review group meetings with providers. This may also be tested at service site quality assurance visits.

Infection prevention

We will drive improvements that reduce the incidence of healthcare acquired infections by taking a proactive approach to achieving reduction targets, including through the development of a two-year clinical strategy.

Infectious outbreaks can affect the delivery of local services, especially during the winter period, resulting in ward or bay closures in acute and community in-patient areas and nursing homes. To manage this effectively, we have agreed a system-wide approach to managing infectious outbreaks during periods of escalation which includes the management of influenza in and out of season. Implementation of this system-wide protocol will mitigate against risks to manage outbreak situations.

Workforce development

The commissioning quality team will work with providers to ensure they: have effective retention plans in place that focus on engaging and empowering the workforce; understand and are acting upon insights such as the reasons why people leave; and are taking sustainable action to retain staff. We will also work closely with trusts to ensure that safer staffing levels are maintained through robust clinical risk assessment. Local workstreams include:

- Apprenticeships – assistant practitioners and nurse associates
- Reduction in nursing vacancies, with a focus on learning disabilities and practice nurses
- Work with Health Education England (HEE) to influence education commissioning, reduce attrition, increase clinical placements, and make Sussex the 'Best Place to Work'
- International recruitment programme
- Retention: 'Best Place to Work' initiatives for all clinical staff groups supported by our ICS workforce workstream, HEE and the SES Training Hub
- Leadership development and talent management.

Progress updates on the above initiatives will be provided at contractual quality review meetings.

Safeguarding adults, children and looked after children

The safeguarding team holds statutory responsibilities in relation to safeguarding adults, children and looked after children within our local populations. This includes the requirement for providers to complete bi-annual self-assessments against an approved Safeguarding Assurance Framework and submission of quarterly exceptions reports.

The work undertaken by the safeguarding team includes taking into account national changes, influencing local activity and developments, and maintaining oversight of any actions being taken to mitigate any significant safeguarding risks.

During the period of our five-year strategy, work will include implementation of the new arrangements for 'Working Together to Safeguard Children' and of any needed improvements arising from the CQC inspection undertaken in Brighton & Hove in July 2019, focussing on safeguarding of children and Looked After Children.

Improving the patient's experience

- System learning from incidents and from complaints and feedback. This comes from patient reference groups/patient participation groups and campaigns such as 'You Said We Did' and 'The Big Conversation'.
- Involving and engaging patients and the public in developing, reviewing, decommissioning and recommissioning local services. Over 1,500 people have contributed to our strategy through local events on the Long Term Plan and Healthwatch events. The public will have the opportunity to provide feedback on our strategy, including on key clinical priorities and the reorganisation of local services.
- Social prescribing to reduce inequalities in access and health outcomes.
- Improving access, early diagnosis, and personalised support to help people self-manage long term conditions.

10.3.   **Moving into operational delivery planning**

Our Strategy Delivery Plan aims to deliver better health and care outcomes for our population by

reforming how our Sussex health and care organisations work together, transforming patient pathways, and delivering the significant number of initiatives included within the Long Term Plan. This must be delivered in the context of a challenged health and care economy with increasingly stringent financial controls and a significant workforce gap, as well as a wider national context of declining performance against key access standards.

We are committed to delivering against our strategic vision as described in this plan, but we also appreciate that delivery of all these commitments will require profound and extensive system transformation.

As we move into operational delivery planning, we will develop and agree a Sussex-wide prioritisation methodology and framework, which can be used for decision making at all levels across Sussex. This prioritisation framework will allow us to collectively:

- Prioritise the right changes, service models or innovations, targeting those that will deliver the greatest value, and help us to focus system-wide resource and effort
- Have a fair, transparent and robust decision making process which can be applied consistently at system, place and neighbourhood level
- Ensure choices are consistent and coherent with our strategic vision
- Enable delegated decision making, where appropriate, to provide us with the bandwidth to make decisions at different levels.

We have developed a draft prioritisation framework to test and agree across the partnership, which is based upon alignment to our strategy, impact and resource requirements:

Category	Element to consider and score against
Alignment to Sussex Partnership need or priority	Extent to which idea/desired change **addresses a Population Health Check need**
	Extent to which idea/desired change **addresses an NHS Long Term Plan 'must-do'** or priority
	Extent to which idea/desired change **aligns with over-riding ICS strategy**
Impact or outcome	Estimated **size and reach of positive impact on patient-defined outcome,** and when it will occur o To consider number of people impacted, and size of impact on each individual, and time lag before impact seen
	Extent to which idea/desired change **addresses the 'three gaps'** o Health and wellbeing o Quality o Finance

	Extent to which the idea or desired change has **unintended negative consequences** in other parts of the system, which could include: - o Compromising access – e.g. closure of services elsewhere in the system - o Compromising quality – e.g. pulling expertise away from areas of need - o Compromising sustainability – e.g. reducing activity to below sustainable levels elsewhere in the system
Resource required	**Financial investment or cost** of progressing and delivering idea/desired change - o To include the cost of disinvesting in other ideas, initiatives or services
	Non-financial resource required to progress and deliver idea, to include: - o Time - o Space - o People
	Ease of implementation and likelihood of success, including size of barriers to delivery

Figure 78: Draft prioritisation framework

While our Strategic Delivery Plan sets out what we want to achieve and the principles of how we will work together differently, our operational planning will set out how we will achieve this, what needs to change to enable this, and how we will monitor achievement of our objectives.

Starting in October 2019, we are asking each of our programmes to build upon their strategic planning and move immediately into operational planning, using the delivery framework below as a consistent way of framing our operational plans.
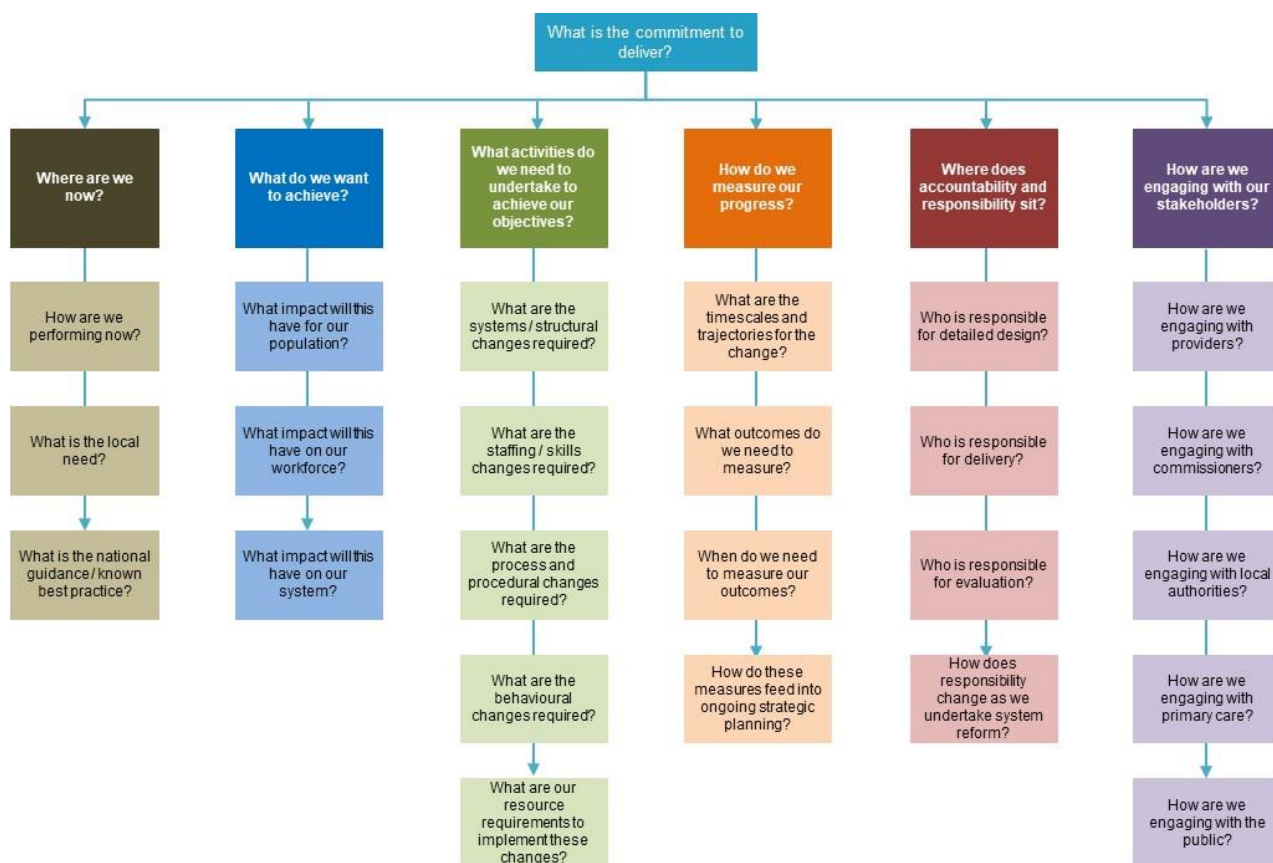
Working in partnership across Sussex

Figure 79: Draft delivery framework for programmes to use as they move into operational planning

10.4. **Major risks and mitigating actions**

The following list of major risks to delivering the Strategy Delivery Plan and mitigating actions is shown below.

Note: This list will continue to develop with ongoing input from each workstream and risk owner.

Risk description	L	I	Score	Owner	Mitigation
Unable to deliver financial improvement trajectory leading to growing deficit and loss of transformation funding	4	4	16	Finance Group	Monthly financial reporting process overseen by Finance Group, which monitors year-to-date position. Key issues and significant variance from trajectory together with mitigating actions. System assurance meetings monitor financial position at ICP/place-based level and develop mitigating actions.
Lack of investment in key areas leads to constraint on delivery	4	4	16	Partnership Executive	Strong governance of programmes to ensure delivery and feedback on performance. Regular reporting to

Page 179 of 185

of ambitions					enable targeting of investment into key areas of delivery.
Insufficient capacity within partner organisations to progress all ambitions in the plan to the timetable set out	4	4	16	Partnership Executive	Allocated resource available from to priority areas. Where resource cannot be identified (e.g. not recruited) review prioritisation of plans.
Workforce planning assumptions are not correct leading to actions not adequately addressing them	4	4	16	LWAB	Regular review of planning assumptions by monitoring current workforce position in Strategic Workforce Group, and of future activity assumptions with Finance Group.
Role and aims of the Partnership are not clearly articulated leading to confusion and misalignment	3	5	15	Partnership Executive	Re-state the aims and purpose of the Partnership through the Local Strategic Plan.
Transformational changes required to secondary and tertiary care services are not undertaken in a managed way, leading to increased **unsustainability of acute services**	3	5	15	Sussex Acute Collaborative Network	SACN to identify current and potential fragile services and ensure that Sussex-wide proposals are developed to address these to ensure long term clinical sustainability.
Lack of clarity around priorities and responsibilities leading to delays and poor delivery	5	3	15	Partnership Executive	Coordination of the Partnership Population Heath Check. Local Strategic Plan and response to the NHS Long Term Plan.
Population health and commissioning outcomes are insufficiently supported leading to poor planning and delivery	3	4	12	Directors of Strategy	Continued Director of Strategy engagement with prospective partner organisations at Partnership Executive; at place; and one-to – one. Directors of Strategy and Communications work with prospective partners to develop strategy to raise awareness of population health amongst partners

					and with communities.
Lack of agreement about implementation of some initiatives, leading to delays or poor delivery of benefits	4	3	12	Partnership Executive	Open discussion with leaders in partner organisations. Where appropriate facilitation of discussion on priorities.
Estates challenges and timescales constrain acute trusts' ability to deliver the optimum service model for UTC services	4	3	12	UEC group	Change in estate requirements to be understood and assessed against pathway impact. This will form part of the NHSE-I assurance process. Period of transition involving workarounds to ensure the core 27 standards can still be met and access to services is not constrained.
Insufficient focus on patient care during system transitions, jeopardising continuity, safety or quality	3	4	12	Clinical and Professional Cabinet	Major change programmesratified by the Clinical and Professional Cabinet to ensure appropriate clinical engagement and patient focus. Revised Quality Impact Assessment Policy used to assess the impact for patients in all programmes.
Key information is unavailable across the system to inform strategy and action	3	4	12	Directors of Strategy	Work to identify missing information and agree approaches to gathering it (e.g. information on student fill and attrition rates).
Lack of genuine collaborative and transparent joint working leading to misaligned incentives and poor delivery	3	4	12	Partnership Executive	Agreement between organisations to share data. Open-book approach to planning and a move towards strategic commissioning.
Excessive focus on NHS acute services to the detriment of local authorities, primary care, community care and	3	4	12	Partnership Executive	Formal involvement of local authorities and primary care in the working of the Partnership. Collaboration beyond health partners, to include the voluntary sector.

Working in partnership across Sussex

prevention					
System financially challenged, in terms of both revenue and capital, impacting its relationship with regulators	3	4	12	Partnership Executive	Open-book collaborative working in STP Finance Group. Aligned responses to regulators from STP, rather than organisations acting independently.
Workforce interventions do not have the planned impact – leading to the workforce plan not being achieved to the planned timetable	3	4	12	LWAB	Monitor impact of workforce interventions through LWAB and sub-groups. Adjust plans or develop further workforce interventions as appropriate.
Priority clinical group workforce plans are not sufficiently clear to enable timely development of workforce plans	4	3	12	LWAB	Support priority clinical groups to develop their workforce plans.
Partnership infrastructure is unclear with poorly established governance and leadership leading to lack of delivery capability	2	5	10	Partnership Executive	Continued strengthening and formalisation of STP governance. Identification of STP/ICS Lead, with authority/credibility to act.
Lack of dedicated resource to deliver the Partnership aims	2	5	10	Portfolio Delivery Group	Dedicated internal resource identified by all organisations, to work on Partnership issues.
Fixed term contracts for programme resources end in March, potentially disrupting planning and delivery	2	5	10	Portfolio Delivery Group	Develop transition and continuity plans to enable internal organisational resource to continue work as needed.
Variation in approach between partners means that financial efficiencies take more time than	3	3	9	Partnership Executive	Ensure alignment of approach through the development of the Local Strategic Plan and monthly meetings to review strategic priorities and planning.

Page 182 of 185

planned					
CCG headcount reduction means that we are relying on staff and managers who are disaffected to perform key transition functions leading to delays on poor performance	3	3	9	SES transition	Deliver an honest, open and transparent process with CCG managers and staff ensuring that they are engaged, and that the rationale for change is clearly and compassionately articulated.
Priority clinical group workforce plans may **increase demand for staff groups** in short supply – affecting the delivery of these plans and/or current services	3	3	9	LWAB	Workforce plans for new services reflect current work supply and phasing of implementation is coordinated with relevant partners.
Retention and/or staff engagement may decrease as a result of workforce transformation	3	3	9	LWAB	Workforce transformation planned and communicated clearly to staff, considering best practice HR and OD practices.
Workstream **does not identify appropriate practical metrics** to measure the impact of actions	3	3	9	LWAB	LWAB oversee the identification of suitable metrics. Where appropriate this is informed by third party advice on evaluation (e.g. AHSN, universities).
Key information is not available to inform strategy and action	3	3	9	LWAB	LWAB works to identify missing information and agree approaches to gathering it (e.g. information on student fill and attrition rates).
There is **insufficient capacity within partner organisations** and/or HCP workforce team to progress all ambitions in the plan to the timetable set out	3	3	9	LWAB	Allocated resource available from HEE and NHSI/E to priority areas. Where resource can not be identified (e.g. not recruited) review prioritisation of plans.

Working in partnership across Sussex

Partner organisations do not agree about implementation of some workforce initiatives, diminishing the impact of work across the system	3	3	9	LWAB	Open discussion with leaders in partner organisations. Where appropriate facilitation of discussion on priorities.
CCG staff consultation slips or needs to take more than 30 days, meaning staff will be going through change during peak winter season and Christmas	2	4	8	SES Transition Board	Develop and manage a robust consultation process, in which issues and concerns are quickly resolved or escalated to ensure timelines are met.
Financial planning assumptions are not agreed by system partners leading to dis-coordinated planning and misaligned incentives	2	4	8	Finance Group	The financial framework is developed by the Finance Group to underpin the financial strategy. We have an open and transparent Finance Group and a system-wide financial model with collaborative system-wide input which informs strategic planning.
ICP footprints cannot be agreed leading to delays	2	4	8	Directors of Strategy	Continued Director of Strategy engagement with prospective partner organisations at Partnership executive; at place; and one-to–one
Misaligned organisational incentives present a risk to system-wide financial improvement and sustainability	2	4	8	Finance Group	The majority of contracts in the system are based upon aligned incentives, which mitigates the risk of provider over-performance on activity. Finance Group are currently examining options with the support of the national payment reform team to move towards more sophisticated risk sharing blended payment models.
Complexity of overall programme of work with all partner organisations leads to **unplanned and/or**	3	2	6	LWAB	Oversight of development of workforce interventions through robust LWAB governance structure. Monitoring of impact of workforce

Working in partnership across Sussex

unintended workforce implications					interventions through agreed metrics and local intelligence.
Review by NHS X delays or stops national digital funding initiatives	2	3	6	Digital Lead	Close relationship management with NHS E/I to ensure targeting of investment opportunities, including ability to respond rapidly. Successful outcomes and strong positive feedback to recent bidding is improving the position.
East Surrey transition delayed meaning Sussex will not be able to fully transition to shadow form	1	4	4	SES transition	Co-define and drive a clear transition plan for East Surrey, ensuring that there is appropriate governance and a clear escalation route to manage any slippage.

Working in partnership across Sussex