

East Sussex Place-Based Response to the Long Term Plan



Drafting note: This draft plan reflects our current understanding of the plans, priorities and next steps for our system, noting that some areas of the plan have already been initiated and some are at an earlier stage of development, programme definition and work up. The contents are being tested across our system and key stakeholders to further scope, shape and agree programme plans for 2020/21 and beyond to meet the Sussex Health and Care Partnership submission deadline to NHS England of 15th November, and may change as a result.

East Sussex Health and Social Care Plan

28th October 2019

Draft v5



Patient-centred
Partnership Transformation
Integration Sustainability 257 Sussex Health
Social care

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Appendices *(Drafting Note: these are in process of being finalised by our system stakeholders and are still subject to change. The complete set will be included in the final draft)*

- Appendix 1 Prevention, universal personal care and reducing health inequalities - high level programme description
- Appendix 2 Children and Young People - high level programme description
- Appendix 3 Community - high level programme description
- Appendix 4 Urgent Care - high level programme description
- Appendix 5 Planned Care - high level programme description
- Appendix 6 Mental Health - high level programme description

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1. East Sussex Health and Social Care Plan

1.1. Introduction and context

The Sussex Health and Care Partnership (SHACP) is required to submit medium term plans covering the expectations set out in the NHS Long Term Plan (LTP) to NHS England (NHSE). This includes the requirement to “deliver a new service model for the 21st Century”, and the transformation and integration plans that will need to be progressed to deliver this. The overarching Sussex-wide submission is a health and care Strategy Delivery Plan covering:

- Sussex-wide plans across specific priority clinical areas, including: Mental Health; Cancer; Prevention; Urgent and Emergency Care; Stroke; Diabetes; Transforming Care Partnership (covering learning disabilities and autism for people with high support needs); Stroke; Diabetes; Maternity, and; reducing unwarranted clinical variation focussing on cardiovascular disease, musculoskeletal conditions and falls and fractures
- Three place plans based on upper tier Local Authority areas - covering East Sussex, West Sussex and Brighton and Hove, outlining our action to deliver NHS LTP commitments and priorities to meet local population health and social care needs
- Sussex-wide plans for workforce, digital and estates
- The finance and activity modelling that will underpin these plans.

Our local East Sussex plan is a joint health and social care plan, which reflects the integrated working in East Sussex and builds on the progress we have made locally and the priorities that we have been working on in 2019/20. Developed in partnership, the plan sets out how we will work together to address both the commitments in the NHS LTP and our local East Sussex priorities by ensuring there is a clear East Sussex health and social care plan to align with, and be part of, the SHACP Strategy Delivery Plan.

This plan has been informed by the national and international evidence base for integrated care to date and our own local development work on our journey towards integration since 2014. We have used benchmarking with tools such as Get It Right First Time, Right Care, and Model Hospital, and a series of recent independent reviews have helped us to further understand the drivers of demand, enabling us to further consolidate our objectives to support improvements to quality of care and the ongoing financial recovery and stabilisation of our system.

Our work on integration to date provides a firm foundation for the next steps as it has piloted and delivered a range of improvements on our journey to a new model of integrated care, including:

- A comprehensive and co-ordinated range of preventative services including; the Healthy Child Programme; One You East Sussex; Making Every Contact Count, Healthy Hastings and Rother, aimed at reducing health inequalities in our most disadvantaged communities; Good Neighbour Schemes; taking forward the Patient Activation Measure and Shared Decision-Making to support greater levels of self-care, and; joint commissioning a range of early intervention and prevention services and support from the voluntary and community Sector (VCS), including support for carers
- Ongoing development of community health and social care services and initiatives, including integrated health and social care teams, crisis response and proactive care, the Dementia Golden Ticket; Health and Social Care Connect now available 24/7, and; the Joint Community Reablement Service

- Strong whole system performance against the Better Care Fund targets and the Care Quality Commission Local Area Review
- Piloting an integrated Outcomes Framework to better enable us to measure whether our work as a system (activity) was having the desired results (outcomes)
- Developing our approach to understanding and using our collective resources on a system-wide basis for the benefit of our population.

Our emphasis in this plan is on the transformation priorities we need to deliver jointly as a health and social care system to meet the future health and care needs of our population. The plan sets out the priorities for programmes of change covering **prevention, community, community, urgent care, planned care and mental health** and how we will work with Primary Care Networks (PCNs), the voluntary and community sector (VCS) and others to support delivery to deliver a “new service model for the 21st century”¹ grounded in the needs of our local population. The plan also describes the local implications for workforce planning, IT and digital and estates.

Our local plan will form the platform for taking forward developing our local Integrated Care Partnership arrangements, as part of the wider development of the Sussex Integrated Care System. In summary our joint plan addresses:

- The NHS LTP commitments by ensuring there is a clear East Sussex plan for our place that also contributes to, and integrates with, the SHACP Strategy Delivery Plan
- The needs of the whole population of East Sussex across physical and mental health, and health and social care services for children and adults from improving health and prevention through to primary and hospital-based care
- A forward view from 2019/20 until 2023/24, taking fully into account the progress made to date and the priorities we have agreed, which are also consistent with the NHS LTP
- The priorities in East Sussex for transformation and integration, and the work in 2020/21 needed to meet the health and care needs of our population and reduce health inequalities, and deliver outcomes on a sustainable basis
- The financial model and infrastructure requirements that will underpin this
- The arrangements for taking forward our Integrated Care Partnership and working with our PCNs, the VCS and wider partners to enable stronger coordination of health and care delivery to our population, making best use of our collective resources, and how integrated population health and social care commissioning will be shaped in East Sussex
- How we will build on the comprehensive approaches to engagement undertaken to date and create a framework of continuous engagement with our stakeholders to underpin and inform our plans.

1.2. Our population health and social care needs

East Sussex has a varied and diverse population and is a county with contrasting characteristics across urban and rural communities. There are approximately 555,110 people living in East Sussex. In summary, our population has the following characteristics and health and care needs:

- The number of young people (aged 0-17) will increase by 3% in the next three years
- The proportion of people over 65 in East Sussex is considerably higher than nationally – 26% in East Sussex compared to 18% in England. By 2023 this will have risen to 27% (19% in England)

¹ NHS Long Term Plan Implementation Framework(July 2019) a copy can be found [here](#)

- The proportion of those aged over 85 is already significantly higher in East Sussex than nationally and will continue to rise sharply. It is this group that are the most likely to need our services
- Health and its determinants are not distributed evenly across the county, with a strong link between poverty and poor outcomes; rurality can also impact access to services
- The number of children in need of help and protection is rising locally and nationally, linked to the increase in families experiencing financial difficulties
- There is a growth in the numbers of children with statements of SEND or Education Health and Care Plans, some of whom will have complex medical and care needs
- Demand for health and social care will continue to increase, both as a result of the growth in the proportion of older people in the population and the complexity of their needs with increasing longevity, frailty and multi-morbidity; on average men spend the last 15.5 years of life in poorer health, while women spend 20.2 years in poorer health
- There is a clear gap in life expectancy between people who live in the most and least deprived areas of the county; this gap is 7 years for men and 4.3 years for women while ward level differences are even greater.

In summary, East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country. Within this, many people live their later years in ill-health, often with more than one long term condition, and this is driving increasing demand and pressure on health and care services and resources. Reducing health inequalities and the gap in life expectancy in the county requires coordinated action with services that impact on the wider determinants of health, such as housing, employment and leisure, as well as targeted approaches to empower people to make healthy choices across the whole life course to improve outcomes.

In the long term, for services to be sustainable for everyone who needs them, there is a need for a new model of care to proactively support the older and frail population, and those with multiple long term conditions, through a strong infrastructure of responsive, coordinated and integrated services delivered in communities. This needs to work with people's strengths to help them feel in control of their conditions with easy access to support from health and social care professionals in multi-disciplinary teams when it is needed. Personalised care, shared decision-making with clinical and care professionals and support to self-manage conditions, for example, through the innovative use of digital are all features of a new model of care for the 21st Century.

The advent of PCNs with a focus on proactively managing population health and better anticipating care needs, and integrated working across health and social care, will enable us to deliver the best possible outcomes for local people, and achieve the best use of collective public resources in East Sussex. There is a strong national and international evidence base that demonstrates the value of integrated working in improving patient and client experience and outcomes, as well as better value for money. Overall this will help to moderate demand for hospital services, protecting them so they are available when they are most needed by our population.

The information about East Sussex that has been used to understand our population health and care needs and the priorities for East Sussex can be found in the following documents:

East Sussex Joint Strategic Needs Assessment

<http://www.eastsussexjsna.org.uk/>

Director of Public Health Report 2018/19

<http://www.eastsussexjsna.org.uk/publichealthreports>

State of the County 2019, Focus on East Sussex' (July 2019)

<https://www.eastsussex.gov.uk/yourcouncil/about/keydocuments/stateofthe-county/>

Supporting People to Live Well in East Sussex', the market position statement for adult services and support (April 2019)

<https://www.eastsussex.gov.uk/media/13531/market-position-statement-2019.pdf>

Sussex and East Surrey Sustainable Transformation Partnership Population Health Check

<https://www.seshealthandcare.org.uk/2019/02/population-health-check-published-across-the-stp/>

1.3. Who we are – our health and care system

The diagram below shows the health and care organisations who work together to deliver health and care in East Sussex across primary, community, acute, mental health and social care and housing, and the wide range of services and assets we have in our communities that impact on people's health and wellbeing.



Figure 1: Health and Care organisations in East Sussex

Some of our population accesses hospital-based care outside of East Sussex, and we will work with partners outside of the East Sussex system, for example providers, Primary Care Networks, other Integrated Care Partnerships, STPs and Integrated Care Systems as they emerge, to support integrated care for our population.

1.4. Where we are now

The longer term overarching outcomes we have been working towards in East Sussex are improving population health, improving the quality and experience of care, and improving the financial sustainability of services. In recent years we have progressed our integrated working in East Sussex through two programmes; East Sussex Better Together (ESBT) and Connecting 4 You (C4Y). From 2019/20 we have agreed to bring these two programmes together to provide the foundation for a single East Sussex Health and Social Care Programme.

During the latter part of 2018/19 and early 2019/20 we have taken steps as a system to secure agreement for the following:

- Bringing together our two East Sussex programmes (C4Y and ESBT) into a single programme for health and social care integration covering our whole population
- Developing a joint East Sussex longer term plan for integration to take us beyond our immediate programme priorities in 2019/20, to address both local East Sussex health and social care priorities and delivering the NHS LTP
- Putting in place partnership governance arrangements for our system to support this work, including reinforcing the system oversight role of our Health and Wellbeing Board (HWB). It is expected that this governance will evolve further as we move into the next phase of our plan and programme
- Taking forward a proposal for our three East Sussex Clinical Commissioning Groups (CCGs) to merge into a single CCG for East Sussex (subject to application and approval by NHS England)
- In the context of the SHACP ambition to become a Sussex Integrated Care System (ICS):
 - Developing integrated population health and care commissioning within East Sussex, as part of the wider strategic commissioning function of the SHACP
 - Developing an Integrated Care Partnership (ICP) in East Sussex to support integrated delivery of health and social care, mirroring our population health and care commissioning footprint.

1.5. Where we want to get to

Our immediate programme and organisational priorities for 2019/20 reflected the continued need for grip on financial recovery; reducing pressure on hospital service delivery; improving community health and social care responsiveness, and; ensuring good use of, and shorter waits for, planned care. This was achieved through consolidating the financial recovery work and ESBT and C4Y objectives into a single programme with priorities for the next 6-12 months across urgent care, planned care and community.

Alongside delivery of 2019/20 plans our key priority in East Sussex has been to develop a longer term plan. This will enable health and social care in East Sussex to describe our next steps, building on the plans that are currently being implemented. Aligned to the SHACP Strategy Delivery Plan, the plan strengthens the whole population focus across the East Sussex health and social care economy, as well as inform the priorities and plans for 2020/21.

In summary, our East Sussex Plan is a joint health and social care plan that builds on what has already been delivered, to produce an up to date statement about our joint programme and integration plans for the next three to five years, covering:

1. The needs of our whole East Sussex population and the outcomes required to meet them

2. Our plans for driving the transformation and integration required to meet population health and care needs, reduce health inequalities and deliver longer-term sustainability, including our priorities for 2020/21
3. The finance and activity modelling that will underpin this across the next three to five years
4. The development of our East Sussex Integrated Care Partnership (ICP) and integrated delivery with our Primary Care Networks (PCNs), with integrated population health and care commissioning arrangements.

1.6. What we want to deliver

Informed by our local East Sussex County Council priorities² and NHS Long Term Plan^{3,4} commitments, and engagement with our local communities, we expect to build on our integration work to date to deliver:

- A comprehensive approach to prevention, universal personal care and reducing health inequalities that cuts across our key clinical priorities and care pathways from supporting healthy lifestyles and wellbeing, greater levels of self-management, shared decision-making, and personalised care and support planning, through to early intervention, proactive care and reablement
- Full implementation of a common operating model for integrated community health and social care, working with PCNs and the VCS to jointly deliver greater community health responsiveness in 2020/21, including:
 - Improved crisis response within two hours and reablement care within two days
 - Anticipatory care
 - Enhanced Health in Care Homes
 - Structured medication review for priority groups
 - Personalised care and support planning, and early cancer diagnosis support
 - Social prescribing and community-based support
 - Better identification and support to improve outcomes for carers
 - The continued implementation of Extended Access in 2019/20 and 2020/21
 - Building the capacity, workforce and partnerships to do this
- A description of our financial model from 2020/21 to 2023/24 that demonstrates the shift in investment to primary care and community health care, including meeting the new primary medical and community health services funding guarantee
- Close system working between our East Sussex CCGs, East Sussex County Council, East Sussex Healthcare NHS Trust, Sussex Partnership NHS Foundation Trust, Sussex Community NHS Foundation Trust, and our local PCNs, to ensure that Sussex-wide strategies and developments align with our local plans for integrated community health and social care and a comprehensive approach to prevention, universal personal care and reducing health inequalities
- Close system working across the local NHS and children's social care to deliver ESCC and NHS LTP priorities to ensure age-appropriate integrated care; integrating physical and mental health services; joint working between primary, community and acute services, and; supporting transition to adult services
- The continued implementation of our urgent care plans to reduce pressure on emergency hospital services including:

² 'State of the County 2019, Focus on East Sussex' (July 2019), a copy can be found [here](#)

³ NHS Long Term Plan (January 2019), a copy can be found [here](#)

⁴ NHS Long Term Plan Implementation Framework(July 2019) a copy can be found [here](#)

- Meeting the A&E standard and agreed metrics for Same Day Emergency Care, and urgent and emergency care
- Implementation of our integrated urgent care model and an integrated network of community and hospital-based care
- Implementing Urgent Treatment Centres by December 2019
- Implementing the new 111 and Clinical Assessment Service (CAS) by April 2020
- The continued implementation of our planned care programme including:
 - Increasing elective care activity to reduce elective waiting lists
 - Enabling choice through expanding digital and online services
 - Digitally enabling primary and outpatient care through the increased use of digital tools to transform how outpatient services are offered, and providing more options for virtual outpatient appointments in identified priority specialties, working with the Sussex Outpatient Transformation Board
 - Scaling up provision of First Contact Practitioners to enable faster access to diagnosis and treatment for people with musculoskeletal conditions and supporting more patients to effectively self-manage their conditions
- Proposals for implementing our East Sussex **Integrated Care Partnership** model to better enable delivery of these principles and priorities, as part of the wider development of the SHACP Integrated Care System.

1.7. How we will deliver against the NHS Long Term Plan commitments and local priorities

Our local East Sussex work on integration and transformation to date aligns well with expectations set out in the NHS LTP and Implementation Framework. We have undertaken analysis that captures how we anticipate delivering commitments in the NHS LTP and our local priorities. This is being used to inform:

- Our individual organisational corporate strategies and operational business planning processes for 2020/21 and beyond, and the partnerships, programmes and projects through which we will deliver improvements to the quality of care
- Alignment with the SHACP Strategy Delivery Plan clinical priorities and plans to support local implementation and delivery, including Sussex-wide strategies for workforce, digital and estates.

In addition, the LTP commitments have been consolidated with our local understanding of the priorities and objectives for our system to date, and the evidence base arising from diagnostic work in 2018/19 on the drivers of our system deficit at that time, and benchmarking tools such as Model Hospital, Get it Right First Time and NHS Right Care. This has given us a set of key priorities we need to focus on as a system in 2020/21, to drive the changes needed to meet the health and care needs of our population sustainably in the coming years. The priorities will be used to set objectives and Key Performance Indicators (KPIs) for our work programmes in 2020/21, and our Health and Wellbeing Board and supporting system partnership governance will oversee delivery.

The priorities reflect our current understanding of the plans and next steps for our system, noting that some areas of the plan have already been initiated and some are at an earlier stage of development, programme definition and work up. This will continue to be tested across our system and key stakeholders to further scope, shape and agree programme plans for 2020/21 and beyond. Fundamental to this will be co-design and co-production of projects and initiatives with patients, clients and carers to ensure that pathways are informed by lived experience.

There are strong links between all the programme areas and changes in one area may have benefits for others. For example, work under the community strand aimed at increasing capacity and efficiency, will enable improved patient flow through hospital and reduced length of stay as

well as improved outcomes for people and their families. Likewise, plans for prevention and personalised care are cross-cutting and elements, will be delivered through linking up priorities across the programme.

The overarching key priorities across prevention, community, urgent care, planned care and mental health are summarised below, and further detail about each area is set out in the Appendices.

Drafting Note: the Appendices are in process of being finalised by our system stakeholders. The complete set will be included in the final draft to meet governance timetables.

1.8. Summary of system priorities for 2020/21

1.8.1 Prevention priorities

To support a comprehensive approach to prevention, universal personal care and reducing health inequalities, in addition to ongoing work on specific activities such as smoking, obesity and alcohol, the following next steps are suggested:

- Use national guidance to set trajectories for narrowing inequalities in 2023/24 and 2028/29 to inform local wider system action planning
- Deliver PCN Network Contract requirements for population risk stratification in 2020/21 to develop a targeted approach to managing population health, and link this with:
 - wider system partnership action to reduce health inequalities, including the further development of Social Prescribing pathways and community-based support in 2020/21 to support mental health and wellbeing
 - the Patient Activation Measure (PAMS) pilot review to inform further development of self-care and self-management
- Ensure that prevention, self-care and self-management, shared decision-making, and personalised care and support planning approaches are built in to identified planned care pathway developments in 2020/21, as appropriate, using NICE guidance and other available condition-specific tools
- Build on the rollout of wheelchair Personal Health Budgets to identify further cohorts of patients for Personal Health Budgets/integrated personal budgets starting with Continuing Healthcare
- Build early intervention, proactive care and reablement focussed aftercare as key features of our developing common operating model for community health and social care services.

1.8.2 Children and Young People priorities

To take forward close system working and ensure age-appropriate integrated care across physical and mental health services; joint working between primary, community and acute services, and; supporting transition to adult services, we are scoping four key priorities for transforming children and young people's services:

Improving children and young people's mental health and emotional wellbeing

- Improving our pathways and commissioning approach particularly with regard to Tier 4/ Secure/Specialist placements
- Developing a coherent Emotional wellbeing strategy which works with our schools to provide appropriate help at the earliest point

Disability Pathways

- Further develop our work around integrating the Education, Health, and Social Care needs of Children and Young People, aimed at producing local solutions.

Safeguarding (including Contextual Safeguarding)

- Further develop our pathways and service offer for young people at risk of criminal and sexual exploitation, physical and sexual harm, alcohol and substance misuse.
- Ensure links into the mental health and wellbeing priority.

Universal Child Health Offer

- Ensure the provision of the Healthy Child Programme for under 5s through the Integrated Health Visiting and Children's Centres service
- Support the preventative health agenda through School Health Service.

1.8.3 Community priorities

Our ongoing focus for the services we provide in people's homes or in the community is to build capacity and clearer pathways for people accessing services, and the support we provide to people after they leave hospital. To enable greater levels of multi-disciplinary working across primary medical care and community health and social care services, work in 2020/21 will centre on the continued implementation of integrated community health and social care and supporting the Network DES Contract specification for PCN development in 2020/21.

Implement Integrated Community Health and Social Care

- Continue to deploy home-based and bed-based Homefirst pathways
- Continue to pilot and roll out co-location and care coordination for those with multiple long term conditions
- Take forward therapy joint working to share skills, best practice and help create capacity
- Develop, agree and implement a common target operating model to support multi-disciplinary working across primary, community health, mental health and social care for 2020/21, taking into account any differences due to local circumstances and evidence, for example, due to patient flows in and out of the county
- Align with pathways for acute hospital (ESHT) Integrated Discharge Team.

PCN Network DES Contract implementation for 2020/21

- Delivery of risk stratification to enable proactive anticipatory care for those with multiple long-term conditions
- Wider development and roll out of Enhanced Care in Care Homes.

1.8.4 Urgent Care priorities

Working with partners across primary care and South East Coast Ambulance Service NHS Foundation Trust, the key focus of the Urgent Care programme is to transform urgent and emergency care services in East Sussex to ensure that, in an emergency, people are treated in the most appropriate place by the right clinical and/or social care service. The priorities are closely aligned with the SHACP plans for Urgent and Emergency Care and include a mix of work to implement Urgent Treatment Centres (UTCs) and local priorities which support ongoing financial recovery and stabilization:

High Intensity Users

- Focus on supporting patients with multiple needs with high numbers of A&E attendances and admissions.

Ambulatory Urgent Care

- Expansion of Ambulatory Emergency Care at both Eastbourne District General Hospital (EDGH) and Conquest Hospital
- Supporting Same Day Emergency Care.

Acute frailty

- Expansion of Acute Frailty teams and pathways to ensure the right support at the front door
- Supporting Same Day Emergency Care.

Enhanced Care in Care Homes

- Implementation of ward rounds to better support patients in care homes, build confidence for staff and avoid unnecessary admissions.

Community Frailty/PEACE planning

- Further rollout of Frailty Practitioner-Led Personalised Advisory Care (PEACE) planning as part of care planning roll-out; supporting cohort of patients in care homes.

Integrated Urgent Care

- Rollout of enhanced NHS 111 and Clinical Assessment Service from 1st April 2020
- Rollout of Urgent Treatment Centres at EDGH, Conquest Hospital and Victoria Hospital
- Direct booking into Improved Access and Walk In Centres
- Increased utilisation of Improved Access capacity.

In addition, the Local A&E Delivery and Urgent Care Oversight Board are in the process of analysing the key drivers of demand behind the recent increases in A&E attendance and admissions to scope further interventions to take forward in winter 2019/20 and 2020/21.

1.8.5 Planned Care priorities

The following areas of focus are suggested to continue transforming our care model, to ensure that those who are referred into hospital are seen and treated as quickly as possible:

Evidenced Based Interventions - maintain the GP Referral rate for East Sussex in the upper quartile of Sussex Health and Care Partnership

- Further mature GP Referral pathways to make best use of resources and time across our system
- Ensure all new processes sustainable and embedded and automatically alert when trending towards an outlier

Outpatients Redesign - offer video outpatient appointments in two specialities

- Pilot technology with most beneficial specialities

Musculoskeletal Services (MSK) - community services meets demand and constitutional waiting standards

- Review MSK community and primary care workforce activity and demand
- Redesign workforce aligning with SHACP MSK, including first contact practitioners, to provide faster diagnosis and treatment
- Review pain management services.

Cancer performance meets constitutional waiting times

- Work with PCNs to improve the uptake of screening targeting those areas with lower uptake and focus on inequalities.
- Develop diagnostics working towards set up of the rapid diagnostic service.
- Continue to ensure implementation of timed pathways so support earlier diagnosis and treatment.
- Ensure personalised care pathways in breast cancer are implemented and plans for other specialties are developed, with prostate and colorectal as priorities for 2020.

East Sussex future Cardiology Care Model agreed, implementation plans approved and resources allocated

1.8.6 Mental Health priorities

Our system work on mental health takes place in the context of the Sussex Health and Care Partnership Mental Health Programme priorities, and the local implementation necessary to support closer system working between physical and mental health, community health and social care, and primary care. The following areas are suggested for further exploration, scoping and shaping the programme of work in East Sussex:

- Single point of access - no 'wrong doors' and access to crisis pathways
- Supporting people in the community through community health and social care teams for adults with severe mental health issues
- Supported Accommodation pathways
- Aftercare and support
- Access to children and young people's mental health services.

1.8.7 End of Life Care

Strategies are in place across East Sussex with the aim of ensuring that high quality, individualised end of life care is effectively coordinated and integrated and provided to all those who need it, regardless of diagnosis or age. This can include ensuring conversations take place about death and dying at an early stage, and supporting people to make plans and communicate these with those who are important to them. This care should extend beyond death to include bereavement and support for families. Plans guiding the full implementation of this approach have been taken forward in 2019/20 and these will need to be continued into 2020/21. The **overall aims** are to:

- **Improve the quality** of end of life care for people in East Sussex by **coordinating care** and integrating pathways and services where possible
- **Improve access** to individualised end of life care, by improving identification of people in their last year of life and having conversations about death and dying early and recording these for use by the whole system
- **Improve palliative care through the identification** of those living with life limiting conditions and providing appropriate services for individuals and their families
- **Improve the skills, confidence and capability** of those who care for people at the end of life by providing training and learning opportunities to staff across the whole health system including non-NHS carers.

Further detail is included in Appendix 5 (*to be added*) – high level programme priorities for planned care.

2. Summary roadmap

The key milestones for the next five years are:

<p>August – November 2019</p>	<p>East Sussex Health and Social Care Plan development, including:</p> <ul style="list-style-type: none"> • Further refinement of priority-setting, and transformation programme objectives for 2020/21 • Refresh of integrated Outcomes Framework • Testing with local system and stakeholders • Developing proposals for our Integrated Care Partnership for the delivery of health and social care for East Sussex • Developing proposals for the approach to integrated population health and care commissioning in East Sussex • Final submission of the SHACP NHS Long Term Plan Strategy Delivery Plan to NHS England (Sussex-wide plans and place plans for delivering NHS LTP commitments)
<p>December 2019</p>	<ul style="list-style-type: none"> • Health and Wellbeing Board endorses East Sussex Health and Social Care Plan, including: <ul style="list-style-type: none"> ○ Transformation programme priorities and objectives for 2020/21 ○ Proposals for taking forward the Integrated Care Partnership ○ Proposals for taking forward population health and care commissioning
<p>January – March 2020</p>	<ul style="list-style-type: none"> • Further implementation planning for 2020/21
<p>April 2020</p>	<ul style="list-style-type: none"> • East Sussex Clinical Commissioning Groups merger complete, subject to application and approval by NHS England
<p>April 2020 – March 2021</p>	<ul style="list-style-type: none"> • Delivery of 2020/21 transformation programme and LTP priorities • Further implementation (as per agreed proposals) of: <ul style="list-style-type: none"> ○ East Sussex Integrated Care Partnership ○ East Sussex Population Health and Care Commissioning ○ Target common operating model for community health and social care services • Delivery of next wave of PCN Network Contract DES requirements, including: <ul style="list-style-type: none"> ○ Anticipatory Care ○ Enhanced Care in Care Homes • Continued financial stabilisation of system
<p>April 2021 – March 2022</p>	<ul style="list-style-type: none"> • East Sussex Integrated Care Partnership in place • East Sussex Population Health and Care Commissioning in place • Sussex Integrated Care System in place • Continued financial stabilisation of system
<p>April 2022 – March 2023</p>	<ul style="list-style-type: none"> • Consolidation of our Integrated Care Partnership and population health and care commissioning arrangements

April 2023 – March 2024	<ul style="list-style-type: none"> Continued financial stabilisation of system Primary medical and community health service funding guarantee met
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3. Our approach to engaging with our stakeholders

3.1. Background

A comprehensive approach to engagement with patients, clients, our staff, the public and communities across East Sussex has been a strong feature of our health and social care transformation programmes to date. This has been undertaken in partnership with Healthwatch and the Voluntary and Community sector (VCS) and is taken forward at all levels – including representation in strategy and planning, and using co-design principles to involve people in the commissioning of specific services, service design and project development.

Overall strategy has been guided and supported by our East Sussex Communications and Engagement Steering Group which brings together communications and engagement leads from across our health and social care partner organisations, including Healthwatch.

Our approach has also been partly underpinned by the development of an integrated Outcomes Framework in 2017/18, based on what is important to local people about their health and care services. This is collectively owned and shared across our health and social care system. We aim to widen the scope of this Outcomes framework as part of our planning process to ensure it truly reflects the whole East Sussex population.

East Sussex was also involved in the Sussex Health and Care Partnership’s wide ranging public engagement exercise about the NHS Long Term Plan during the Spring of 2019 – the Big Health and Care Conversation, culminating in the report ‘Our Health and Care, Our Future’. This was a programme of engagement that took place across the whole of Sussex, in partnership with Healthwatch, and included events and online surveys. Detail is provided below about how this information has been used to inform and contribute to developing our East Sussex Plan.

3.2. Developing our East Sussex Plan - insight and key themes from recent engagement

A multi-agency East Sussex Plan Task Group has been set up with nominated leads across our system, including representation from Healthwatch and the Voluntary and Community Sector. The Task Group has met twice to scope the work and produce a development framework to guide the programme of work. Additional meetings have taken place to progress work with a range of leads from organisations across public health and prevention, community, urgent care, planned care, mental health, children’s social care, finance, workforce and communications and engagement.

The following work has helped inform and contribute to the development of our East Sussex Plan over the summer:

- An audit of existing insight from recent engagement events and exercises to provide a snapshot of the key themes across East Sussex. This included harvesting the East Sussex insight from the Phase 1 report from the Big Health and Care Conversation and Our Health and Care, Our Future engagement on the NHS LTP (Phase 2 will be added when

available), as well as from the joint Shaping Health and Care events that are specific to East Sussex

- The themes from the audit have been used to help inform the key principles and priorities for our East Sussex Plan, and will continue to be used to help inform our planning and priority setting in the coming weeks. The draft summary of the key themes from the audit is included at the end of this document
- The themes from the audit are also being used as a guide to what matters to people living across East Sussex, as part of updating our integrated Outcomes Framework for 2020/21 and ensuring it continues to be based on what matters to local people about their health and social care services

3.3. Next steps – testing emerging plans

We will further test the key principles and priorities of our East Sussex Plan, and the updates to our integrated Outcomes Framework with our local stakeholders during October and November, ahead of the final draft Plan being brought to the East Sussex Health and Wellbeing Board (HWB) for endorsement in December 2019. This will be done through existing mechanisms such as the Patient Participation Groups Forum, the East Sussex Seniors Association (ESSA), and the East Sussex Inclusion Advisory Group (IAG). These will also align with engagement being coordinated by the SHACP on the Strategy Delivery Plan, supported by a digital approach to make sure we are reaching our broad base of stakeholders who we are regularly in touch with about developments.

Plans are in place to undertake a high level joint Equalities and Health Inequalities Impact Assessment (EHIA) screen of our East Sussex Plan, with a view to flagging potential areas where future EHIAs will be needed for specific projects and initiatives. This will inform the framework for continuous engagement with all of our stakeholders.

3.4. Informing ongoing planning and implementation

Building on the comprehensive approaches to engagement undertaken to date, the priorities and next steps for transformation and integration that come out of the planning process for the East Sussex Plan will be used to create a framework of continuous engagement with our stakeholders. This will underpin and inform our ongoing system communications and engagement activity in the coming months.

Our system partnership governance has been reviewed and has evolved to ensure a broader system partnership to oversee delivery of the East Sussex Plan and development of our Integrated Care Partnership proposals on behalf of the HWB, through aligning organisational plans across our health, social care and wellbeing system and involving all key stakeholders. More information about this can be found in section 4.

We have recently entered into a new arrangement to strengthen the involvement of voluntary and community partners. The new East Sussex 'Partnership Plus' forum brings partners together to take a different approach to how we work together and more effectively use our combined resources, build on existing skills and knowledge and develop much better ways of working for the benefit of people in East Sussex. A joint planning group has been formed to get things moving to identify community priorities, using our collective knowledge and data and move swiftly to "doing" – taking in action on the wider determinants of health as well as the role of the VCS in delivering health and care services and support.

3.5. Draft summary of key themes from the audit of recent engagement activity in East Sussex

Theme	Which reports?
<p>Joining up health and care services, partnership working and collaboration</p> <ul style="list-style-type: none"> • People told us we needed to have better co-ordination across the health and care system in order to improve people's experience of receiving services and make the system less confusing (pathways, information sharing, joined up working). They talked about the importance of partnership working and involving the right people and organisations, the ongoing challenges to integration, the importance of collaboration and co-design – for example involving Patient Participation Groups (PPGs) in commissioning. In the OH&COF engagement people fed back that the creation of multi-disciplinary 'Health Hubs' was a great opportunity 	<ul style="list-style-type: none"> • Healthwatch • OH&COF⁵ • SH&C⁶ Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation • Listening To You
<p>Communication, access to information, and information sharing</p> <ul style="list-style-type: none"> • People consistently told us we need to improve access to information, and improve communication about services, between staff, between organisations and to patients about their care. People told us we need to have integrated IT systems and record sharing, but that we should consider confidentiality and how people's information is used. 	<ul style="list-style-type: none"> • Healthwatch • OH&COF • SH&C Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation • Listening To You
<p>Digital</p> <ul style="list-style-type: none"> • People gave positive feedback about increasing use of digital services and innovations, and that it could help make best use of resources. They also said we must ensure we don't exclude people who may not be able to access digital services. 	<ul style="list-style-type: none"> • OH&COF • SH&C Spring '18 • SH&C Autumn '18
<p>Staffing, resources and funding</p> <ul style="list-style-type: none"> • People acknowledged increased demand for care and appreciate honest conversations, but also emphasised the importance of having more/enough staff, that resources must be adequately planned for the future and for the population (for example where there is new housing), and gave views on where they thought resources should be directed and how to make best use of existing staff. There is sometimes a mismatch between what people feel they need and what the system is offering. The need for more GPs was a common theme. 	<ul style="list-style-type: none"> • Healthwatch • OH&COF • SH&C Spring '18 • Big Health and Care Conversation • Listening To You
<p>The role of the voluntary and community sector, and social prescribing</p> <ul style="list-style-type: none"> • The importance and value of the voluntary and community sector and social prescribing was highlighted throughout the engagement, and people said that it should be adequately planned 	<ul style="list-style-type: none"> • Healthwatch • OH&COF • SH&C Autumn '18

⁵ Our Health and Care Our Future

⁶ Shaping Health and Care

Theme	Which reports?
<p>and resourced. People taking part in the Healthwatch mental health focus groups said VCS organisations are picking up services no longer provided by the statutory sector.</p>	<ul style="list-style-type: none"> • Big health and Care Conversation
<p>Health inequalities</p> <ul style="list-style-type: none"> • People agreed that there shouldn't be "postcode lotteries" for care, and said that there are still significant health inequalities to address. The issue of transport and access for rural communities was raised consistently. 	<ul style="list-style-type: none"> • Healthwatch • OH&COF • Big Health and Care Conversation
<p>Behaviour change and prevention</p> <ul style="list-style-type: none"> • People are aware of, and agree with, the importance of their own choices in living healthy and independent lives, but said that the healthcare system and staff also play an important role in prevention. People said access to information, education, services and facilities is important, alongside addressing barriers to access. 	<ul style="list-style-type: none"> • Healthwatch • OH&COF • SH&C Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation
<p>Mental health</p> <ul style="list-style-type: none"> • Issues raised around mental health services include access, waiting times, support to meet people's needs, communication with people about their care. Support for those with autism and dementia was also discussed in connection with mental health • Issues raised around young people's mental health services include access to services and experience. 	<ul style="list-style-type: none"> • Healthwatch • OH&COF • Big Health and Care Conversation
<p>Holistic and personalised care</p> <ul style="list-style-type: none"> • People highlighted the importance of a holistic approach and more personalised care, including "non-medical" solutions, a joined up system, and support from healthcare professionals to help them make their own or joint choices. 	<ul style="list-style-type: none"> • Healthwatch • OH&COF • Big Health and Care Conversation
<p>Access to services and experience of services</p> <ul style="list-style-type: none"> • There was lots of feedback about difficulty accessing services or not feeling they are getting enough support. For example, lack of co-ordination in the system, availability and timeliness of appointments, availability of GPs/ HCPs or treatment, continuity of care and gaps in services, and home care provision. As above, support for young people's mental health needs was also a common point of feedback. 	<ul style="list-style-type: none"> • Healthwatch • OH&COF • SH&C Spring '18 • Big Health and Care Conversation • Listening To You
<p>End of life care</p> <ul style="list-style-type: none"> • People highlighted the importance of better conversations and support around end of life care, including conversations with their GP. 	<ul style="list-style-type: none"> • Healthwatch • OH&COF • Big Health and Care Conversation
<p>Multiple and complex needs</p> <ul style="list-style-type: none"> • People with multiple or complex needs find it more difficult to access the support that they need. 	<ul style="list-style-type: none"> • Healthwatch • OH&COF

4. Working together to deliver our plans

4.1 Our partnership governance

We have launched our East Sussex Health and Social Care System Partnership Board. The System Partnership Board is a strategic planning body, enabling us to work together on behalf of the Health and Wellbeing Board to collectively oversee and lead the delivery of the system transformation required to:

- Meet the health and care needs of our population
- Improve the health of our population and reduce health inequalities
- Respond to the NHS Long Term Plan and local priorities in East Sussex through overseeing the strategic development and delivery of our longer term East Sussex Plan, through aligning organisational plans across our health, social care and wellbeing system.

The new System Partnership Board involves a broad membership from across our system to ensure a clear focus on prevention and the wider determinants of health, as well as making improvements to the quality of care we deliver as a system. This includes Primary Care Networks, NHS Providers, District and Borough Councils, Healthwatch and the voluntary sector, alongside East Sussex CCGs and ESCC as statutory health and social care commissioners. The East Sussex Health and Social Care Executive Group, will also continue to meet to ensure a clear focus on the operational performance of our programme priorities. This will be kept under review as our plans for our ICP and broader system working take shape.

The structure below shows the current key elements of our partnership governance and the lines of accountability. It will evolve over time, for example, as our East Sussex Integrated Care Partnership (ICP) emerges.

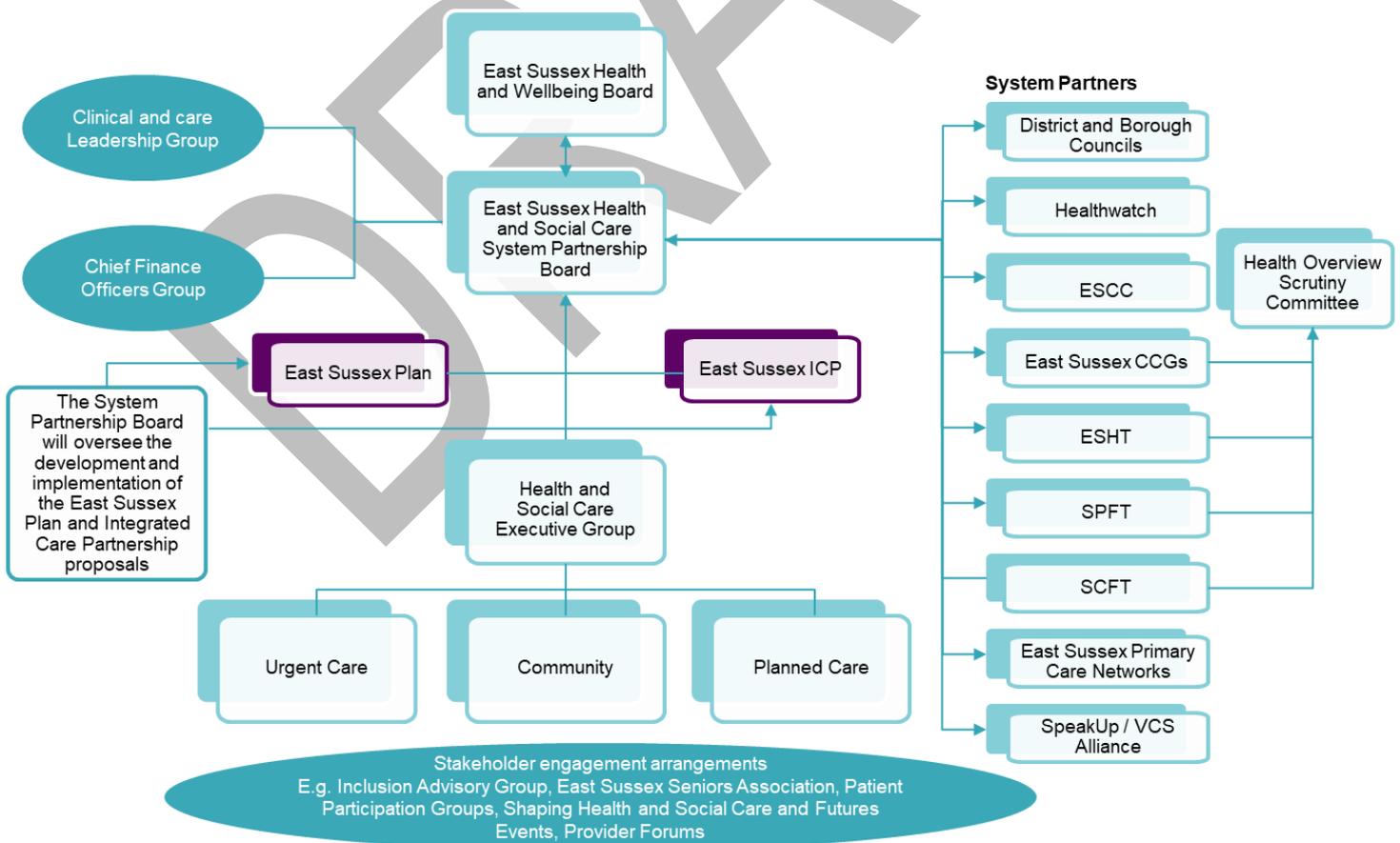


Figure 2: Key elements of Partnership governance

4.2. Developing our Integrated Care Partnership

The System Partnership Board's responsibilities will include developing our future East Sussex Integrated Care Partnership (ICP), with initial proposals being shaped for April 2020. The ICP will ultimately govern how we operate together in a more integrated way in our localities across primary, community, mental health and social care with consistent pathways into and out of hospital care when this is needed, and ensuring strong links with services that impact on the broader determinants of health, for the benefit of our population. Over time it will develop to encompass relationships and pathways with services accessed by our population beyond the geography of East Sussex, for example, specialist services within Sussex and beyond, and acute hospital services provided within Sussex and Kent.

Our ICP will provide the framework for all providers of health, care and support working in East Sussex to come together to plan, organise and deliver services at the optimum scale to support quality, consistency - making the best use of our collective resources to deliver the outcomes and priorities for our population identified in the East Sussex Plan. Proposals will be shaped to cover:

- The longer term objectives for the ICP and the overall model we will be working towards
- The elements that need to be in place by April 2020
- The specific actions that we will take to deliver the agreed ICP April 2020 proposals, for example agreeing and implementing the common operating model
- A framework for managing health and social care resources in East Sussex to deliver the best possible outcomes.

4.3. Supporting Primary Care Network development

There are twelve PCNs in East Sussex, established on footprints reflecting local relationships and previous locality working arrangements. All the PCNs are now operational, with identified Clinical Directors in place, and delivery of the Extended Hours DES under way. An opportunity for PCNs to increase the pace of their partnership work will be provided through the local offer of a PCN accelerator programme during September 2019. Four specific areas of focus have been identified, for PCNs to accelerate and respond to the challenges and focus on:

- The development and acceleration of a PCN to progress at pace, mature and deliver their ambition
- Delivery of the Sussex STP Clinical Variation Programme ambitions and requirements (Musculoskeletal falls, Diabetes, and Cardiovascular disease)
- Responses to the requirements of the LTP (including anticipatory care, personalised care and early diagnosis for cancer)
- Integrated joint working of the PCN with other providers to better support integrated care, MDTs and improve the PCN population health; and better integrate urgent or planned care pathways to improve system flow, avoid admission and improve value for money.

Some PCNs are taking up the opportunities offered through the Additional Roles Reimbursement Scheme (ARRS), such as the employment of social prescribers and pharmacists (this will take into account existing extended roles that we have already implemented in the county), whereas others continue to explore their options. The CCGs are supporting them in these discussions, including exploring the potential for alignment with the current CCG commissioning of social prescribing.

Public Health are working to compile Population Health packs to help PCNs make informed decisions regarding their priorities for development and strategic direction. PCNs are currently completing a self-assessment against the national NHSE maturity matrix, which will help shape

their response to the recently published prospectus detailing the national support offer.

The Director of Primary Care meets regularly with each PCN to discuss their plans and how CCGs can support them, and the wider CCG Primary and Community Care team members are being repositioned as more externally focussed in order to directly support PCNs. To share good practice and ensure progress is maintained, monthly CCG / PCN / provider meetings have been established, commencing in October, and quarterly Sussex wide meetings will commence in November with support from the National Association of Primary Care.

There is a place for collective representation of the East Sussex PCNs on the new Health and Social Care System Partnership Board, alongside ESHT, SCFT, SPFT, the East Sussex CCGs, ESCC and wider system partners including the VCS. The SPB will oversee development of our East Sussex Plan and ICP proposals, including the full implementation of our target operating model for community services, once this has been agreed. Arrangements are being put in place for full engagement of PCNs in the development and design of the target community operating model, including ensuring closer system working and integration with mental health services at the community and locality level.

Work is also being taken forward on developing of Local Commissioned Services (LCS) in the context of PCNs and potential alignment across Sussex to include cancer LCS, respiratory / COPD LCSs and Enhanced Care in Care Homes LCS, and diabetes prevention, with consideration of provision on PCN-basis. The Diabetes prevention LCS will support referrals to the National Diabetes Prevention Programme. This will build on the schemes currently in place in East Sussex to ensure alignment.

There have been approaches to trialling and delivering multi-disciplinary working in community and primary care developed through our integrated care programmes to date. For example, SCFT implemented a programme of Multi-Agency Team meetings (MATs) that bring together GP practices and community health, social care and voluntary sector services to address the needs of the most complex and vulnerable patients. The role and remit of MATs is now under review with SCFT and CCG clinical leads, with a view to re-aligning their operation to the new PCN model of working, including further consideration in the context of the work to develop a common operating model.

5. Supporting our system to deliver our plans

5.1. Our workforce

5.1.1 Sussex wide developments

Across the Sussex Health and Care Partnership Human Resources (HR) and Organisational Development (OD) leads work together to coordinate HR, workforce and OD activities across Sussex including design of development opportunities. In practical terms, the workforce and OD priorities for Sussex have been agreed to ensure delivery against the NHS Interim People Plan and organised into five workstreams, including Talent Management and Leadership Development. Each workstream has, or is developing, a set of objectives and is led by either an HR Director or Chief Nurse or both from within our Sussex system.

One of the underlying themes for several of the workstreams is addressing the skills gap identified following a baseline assessment carried out in the spring, with a particularly focus on nursing vacancy levels.

For primary care, Health Education England (HEE) has produced a new governance structure and standards for the evolving role of Training Hubs, previously known as Community Education Provider Networks (CEPNs).

Sussex Health and Care Partnership have embraced this new way of working and created a Sussex Training Hub that will provide strategic direction for locality training hubs, such as the East Sussex Training Hub. Investment is being made by HEE to ensure the Sussex Training Hub and the locality Training Hubs have the necessary infrastructure to meet the standards required within the HEE maturity matrix, thereby enabling the training hubs to support the development of Primary Care Networks and their workforce plans. For example, this will include Workforce Planning and Workforce Information resources at Sussex Training Hub level to provide a consistent approach to workforce planning in primary care.

5.1.2. East Sussex draft OD Strategy - our strategic vision

Within East Sussex we have established an **East Sussex Organisational Development Network** and a Strategic Workforce Group, to develop the relevant initiatives to ensure our East Sussex workforce of the future is well placed to deliver improved health and care for local people.

East Sussex OD leads have developed a deeper understanding of each other's organisations, building an East Sussex OD Network (the Greenhouse Group) and co-producing a draft 'place' People (OD) Strategy. Our workforce is critical to our success both at a macro and a micro level; our staff can make a success of system-wide transformation and are central to the experience of those who use our services. We believe that, underpinned by staff engagement, there are three key themes to empower our people to deliver the best integrated health and care for local people. We need to build:

- An East Sussex Culture
- A Thriving Workforce
- High Performing System Leadership.

All three themes are critical to East Sussex becoming a high performing system. The model below outlines the interdependency of these themes in delivering the system workforce that we need for the future of health and care locally.



5.1.3. Delivering this strategy

Our East Sussex OD Network will drive the delivery of this strategy supported by the recently trained cohort of 42 OD Practitioners working closely with organisational communications and staff engagement teams. It will be important that this is driven in the context of our local East Sussex work to create an Integrated Care Partnership that is financially sustainable for the future, and also aligns to the Sussex Health and Care Partnership. As such, our clear governance arrangements and senior support for this ambitious strategy are key to its success and delivery.

5.1.4 Translating the strategy into outcomes for local staff and local people

We anticipate that the key outcomes from the delivery of this strategy, based on local experience, specialist expertise and research will be:

- A clear, understood lived vision
- Shared values and behaviours
- Improved motivation, staff retention, ability to recruit
- A stable, adaptable, creative and innovative workforce
- Happy, healthy and productive staff.

5.1.5. East Sussex Workforce priorities

We have an established Strategic Workforce Group (SWG) made up of senior workforce and HR professionals representing each of the East Sussex partner organisations. The SWG initially developed a two year workforce strategy in 2016 designed to support the delivery of the workforce needed to achieve the integrated care models within three priority workstreams (Integrated Locality Teams, Urgent Care and Primary Care).

Each year the SWG reviews its strategic priorities to ensure the strategy continues to reflect the East Sussex workforce needs in terms of closer working and the introduction of new care models. This will play a critical part in furthering the integration agenda and the NHS LTP and local ambitions to implement our ICP and a Sussex Integrated Care System.

East Sussex Locality Training Hub priorities

The East Sussex Locality Training Hub works with available funding to deliver workforce training priorities. For example, HEE KSS has previously provided operational plan funding which was combined with GPFV investment by EHS and HR CCGs to implement care navigation in GP practices, bursaries for newly qualified GPs and funding a two year GP Fellowship programme.

The East Sussex Locality Training Hub will use funding made available through CCGs, NHSE HEE KSS and the SHACP to support the following identified priorities to help address the workforce issues within primary care:

- GP Retention schemes funded via NHSE and the SHACP
- Creation of Educational Incentive scheme/hubs to increase training within GP practices where this is currently lacking
- Support to Primary Care Networks with developing workforce plans (as per the NHS LTP)
- Continued support to practices introducing care navigation.
- Support Social prescribing implementation and ensuring it complements care navigation
- Creation of GP Fellowships (e.g. Digital Fellowship) to improve retention of newly qualified GPs and broaden experience
- Creation of an East Sussex Academy as part of long term recruitment plans.

Priorities to support local transformation

Overall the East Sussex workforce priorities for 2019/20 to help deliver our East Sussex integration and transformation plans have been agreed as follows:

- Support to delivering the Sussex workforce priorities, ensuring East Sussex representation on each of the five Sussex workforce workstreams
- Identify opportunities for working collaboratively in terms of introducing new, blended, and/or enhanced roles to address the skills gap within East Sussex. This covers the potential workforce development needed to support transformation of integrated community and out of hospital care, urgent care, planned care and primary care, as well as the approach to the comprehensive model of personalised care
- Design and delivery of East Sussex OD plan (as described above).

5.2 Digital requirements

The East Sussex Health and Social Care system is delivering on a long term digital strategy to support the care we give our people in line with the NHS Long Term Plan. Over the next five years we will continue to work closely with our partners across Sussex within the Sussex Health and Care Partnership to deliver on the following themes of the Locally Held Care Record (LHCR), remote care and the wider digital strategy:

- **Our Connected Care** – giving the practitioners who care for me the information they need from all the settings in which I receive care; ensuring that I only have to tell my story once; and that my journey through the health and care system is supported by clear messaging from one setting to another about my needs
- **Transforming Outpatients** - patients 'not having to attend outpatients unless they are required to do so', by deploying remote care alternatives to traditional outpatient appointments.
- **Our Personalised Health** – giving me access to, and control over, my own information. This means I will have greater agency in my care, allowing me to better understand my ability to take an active role in my wellbeing. It will allow me to communicate my needs more effectively and in better time with the right care professionals allowing them to deliver their role more effectively. A citizen portal is also being developed within the cancer space. A Personal Health Record (PHR) uses a shared record approach which enables a citizen through a single online identity, to access their health record. Within Sussex there is an ambition for all citizens to have access to their Personal Health Record and the Patient Knows Best solution has been procured to support citizens with multiple co-morbidities. A personalised approach to care that promotes patient empowerment in their health care is a key priority for the Surrey and Sussex Cancer Alliance.
- **Our Population Insight** – allowing our health and care system to have a better sense of itself; a better sense of what care is being delivered within a complex integrated network of health and care providers working as partners to serve 1.8 million people across Sussex; and through the evidence an integrated longitudinal health record for everyone will allow us to obtain, improve the outcomes we deliver through the services we provide

As we deliver the LHCR across the next five years we will also support our health and social care workforce to benefit from a more integrated digital environment, including innovations in practice based on digital opportunities.

LTP	Priority	Themes	East Sussex initiatives
Empowering people	<ul style="list-style-type: none"> • Access to manage care • Long term conditions – telehealth and devices • Patients hold their care plan 	Our Personalised Health	<p>PHR in Cancer, Diabetes and beyond Online consultations</p> <p>Portals in social care</p> <p>Improve digital inclusion in our population</p> <p>Rationalisation of local service directories across CCG and Social care</p> <p>Integrating with the NHS App</p> <p>ESCC is leading work on TELECARE establishing the integrated community diabetes care service which is underpinned by data between GPs and the community.</p>
Supporting health and care professionals	<ul style="list-style-type: none"> • More satisfying place to work – more effective tools • Increasing pace to out of hospital based care 	Our Direct Care	<p>Integrated Care Record allowing professional a better view of the person they are caring for</p> <p>Supporting teams integrated across health and social care to better work together</p> <p>Smarter Working and Agile Practitioner – how technology can be harnessed to support more flexible and effective working practices</p> <p>GP digital fellow – to work with the system to support the move to a digital first model and grow a clinical digital lead network (reference CPILF)</p>
Supporting clinical care	<ul style="list-style-type: none"> • Technologies enabling pathway re-design • Co-production between patients, clinicians and carers 	Our Direct Care, Our Personalised Health, Our Population Insight	<p>Work with the developing LHCR to provide a new set of standards practitioners and service leaders can depend on to design new pathways, and helping to deliver a workforce that understands how digital can transform the way we deliver care.</p> <p>Integrating use of digital across services, removing barriers to sharing care information between providers, and between our population and the practitioners delivering there</p>

LTP	Priority	Themes	East Sussex initiatives
			care, allowing co-production of pathways and people to manage their care. Out of work with the Information Sharing Gateway to provide the governance to support increased sharing and the ES Integrated Care Record and prototype LHCR Orchestration Layer to provide the technology. Digital work stream to support both outpatient and emergency department transformation
Improving population health	<ul style="list-style-type: none"> Population insight to understand greatest health Provide evidence to improve the way we change 	Our Population Insight	East Sussex is an early adopter of the Sussex Integrated Dataset to support the transformation in social care and community health into integrated working by providing the evidence for the benefit of change
Improving clinical efficiency and safety	<ul style="list-style-type: none"> Improving ways of working between practitioners, to allow more effective integrated working 	Out Direct Care	Integrated Care Record and Information Sharing Gateway

Our key NHS healthcare providers will also be working to deliver increased digital capability, in line with the national and regional programmes to ensure that services are digitally enabled. Our providers will agree a trajectory for improvement over the next five years, with associated investment, to build capabilities in key areas, including cybersecurity.

5.3 Estates requirements

5.3.1. Primary Care premises

The delivery of improved GP premises is one cornerstone of the delivery of our LTP commitments, and specifically the future role of primary care and its transformation in relation to the GP Forward View and the Primary Care Networks. The provision of primary care premises that are appropriate, modern and fit for purpose and flexible enough to support the delivery of our plan is therefore key.

The CCGs are continuing their programme of upgrading practice premises in a very challenging financial climate.

5.3.2. Premises Development

Across our CCG footprints we continue to have a number of primary care estate challenges which are exacerbated by ongoing local population growth. These include the size of the premises in

relation to the registered population and the layout and the condition of the buildings, all of which can seriously impact on care delivery in various ways.

The CCGs have therefore been working with their GP membership to assess the suitability of our primary care estate across our footprint. We have undertaken a prioritisation process, to enable us to see which practice developments should be regarded as most urgent and/or important. This has taken account of:

- Available square meterage Net Internal Area (NIA) per 1,000 registered patients
- Known planned housing developments in the area
- Practice-specific issues, such as suitability of facilities, expiry of leases/planning permission
- Any CQC-related issues.

As part of our whole systems approach to locality development for health and social care services and our drive to achieve integrated working, consideration for any new development has also been given to:

- Ensuring practices have the ability to provide access to the full range of locally commissioned services (LCSs) for their patients
- Ensuring there are no estates barriers to the co-ordination of Extended Hours across practices
- Sharing front of house and back office facilities, clinical and non-clinical staff, where this is practical to avoid duplication and achieve economies of scale
- Ensuring estates considerations are no barrier to practices' key role in teaching and training
- Devising flexible approaches and using opportunities afforded by new digital initiatives.

These criteria have been used to prioritise outline proposals from practices for estates developments from a commissioning point of view.

The actual order in which proposals are being developed and presented is dependent on a number of factors, including the urgency with which the partnerships pursue the projects, the congruency of views between possible project partners, the ability to formulate an agreed potential outcome, and also the availability of developable sites and the ability to develop the proposal to financially stay within the framework as set out by the GP Premises Cost Directions.

5.3.4. Development Status

The CCGs are taking forward a significant number of primary care developments simultaneously to ensure that practices and now Primary Care Networks have the capacity and are well placed to deliver the additional services required going forward, including additional PCN services, integrated community hubs, new digitally enabled ways of working and increasing outreach services from secondary care.

In EHS and HR CCGs there are currently eleven new build developments underway or in planning and two significant extensions. This will give each of our eight Primary Care Networks at least one new facility or significant expansion capacity for service developments including those provided under the DES and those provided within the Integrated Hub model.

In order to support the delivery of better quality services and more efficient outcomes, there are 13 active primary care premises developments across EHS and HR. The CCGs plans reflect the need to improve primary care estate and the financial implications of this are scheduled within the five year financial recovery plan.

HWLH CCG currently has one new development underway, which will provide not only a new primary care surgery for the three practices in Lewes, but will also enable integration with other health and social care providers and community and voluntary services.

Status	EHS CCG	HR CCG	HWLH CCG
Project commenced	3	1	1
Approved	3	3	1
OBC	1	2	1
Total	7	6	1

5.3.5. Acute and community estate

We are developing an ambitious programme to address particular areas of concern around ESHT and SCFT and the level of investment required to address the estates maintenance backlog, medical equipment and IT challenges. For ESHT, estate will be addressed through a combination of ESHT resources e.g. depreciation and external bids, PDC, loans etc. ESHT has recently received approval for a loan of £13.86m to address the fire compartmentation issues at Eastbourne DGH. Delivering our urgent care programme will require significant investment at the ‘front door’ of our main emergency departments, alongside the development of Urgent Treatment Centres. This sits alongside significant investment within the hospitals on backlog maintenance and infrastructure, medical equipment and digital capability. Working with and through the SHACP Digital and Estates groups, these plans will continue to be refined and developed over the coming months. Capital schemes to improve clinical outcomes at the “front door” include the development of Single Assessment Unit/UTC at Conquest Hospital (£6.28m) and the development of the UTC at Eastbourne DGH (£3.78m). This is however, wider investment around the front door and does not preclude delivery of the UTC model by December 2019.

Through the development of the SHACP Estates Strategy we are working with colleagues on developing capital bids for the Single Assessment Unit/UTC at Conquest Hospital, UTC at Eastbourne DGH, Cardiac Catheter lab provision, Ophthalmology service modernisation/relocation, Day case unit at EDGH, Non-clinical space rationalisation, Medical Day case unit and Maternity.

SCFT is the main provider of adult community health services in High Weald Lewes and Havens and occupies three community hospitals within the area; Lewes Victoria Hospital, Crowborough Hospital and Uckfield Hospital. NHS Property Services own these buildings and SCFT deliver the services. SCFT has been working with commissioners, GPs and NHS Property Services to develop proposals for an Urgent Teatment Centre at Lewes Victoria Hospital, enabling an enhanced offer for local people in line with our Integrated Urgent Care strategy. There is currently a Minor Injuries Unit at this hospital site and a plan agreed for a brief closure of this service, with interim arrangements to be put in place whilst the redevelopment work takes place in readiness for the UTC to open in Spring 2020. SCFT will work with local GPs using an innovative clinical model to deliver the national standards for UTCs.

The Integrated Primary Urgent Care provision is also being reviewed across High Weald Lewes Havens, and having finalised the plans for the Lewes UTC, the CCG is now exploring options for expanding the offer at Uckfield and Crowborough MIUs with SCFT and other providers, including HERE (who have the contract for Improved Access), IC24, and the recently formed Primary Care Networks.

In the longer term a further review is required to address:

- Distribution of beds to ensure safer staffing, cohorting and to improve system flows (and the use of beds at Newhaven Rehab need to be considered as part of this)
- Address utilisation issues, particularly at Uckfield Community Hospital
- Continued investment to renew diagnostic imaging
- Addressing backlog repairs.

The services and estates mapping will be complex given that the High Weald and Lewes community hospitals face three acute Trusts – ESHT, BSUH, and Maidstone and Tunbridge Wells (Crowborough). A whole system approach will be necessary to determine the required strategic changes to this estate.

SCFT is also working with GPs in Lewes to establish the UTC at Lewes Victoria Hospital and to realise the opportunity of the Northern Quarter development that improves the primary care infrastructure in the town. Where there is no estates project per se, it should be noted that SCFT is committed to improving the integration of community health services in line with PCNs and this will drive future estates planning that will increasingly support primary care and community based health services in a more integrated approach.

ESHT and East Sussex CCGs are working together to redevelop/improve the provision of GP premises for example in Seaford and Newhaven and the establishment of community hubs. Similarly, SCFT is actively engaged with GPs within the Havens PCN to develop the Newhaven Hub, which will enabled the co-location of primary care and community health services (currently based at Newhaven Polyclinic) as well as other public services that have a positive impact on public health, particularly leisure.

Appendices

Appendix 1 Prevention, universal personal care and reducing health inequalities – high level programme description *(to be added)*

Appendix 2 Children and Young People – high level programme description *(to be added)*

Appendix 3 Community – high level programme description *(to be added)*

Appendix 4 Urgent Care – high level programme description *(to be added)*

Appendix 5 Planned Care – high level programme description *(to be added)*

Appendix 5 Mental Health – high level programme description *(to be added)*