APPENDIX 1

Sussex Health and Care Partnership

East Sussex Place-Based Response to the Long Term Plan

East Sussex Health and Social Care Plan

13 November 2019

Draft v6.3

East Sussex County Council

NHS

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Executive Summary

Welcome to our East Sussex Health and Social Care Plan. The plan has been produced by the East Sussex Clinical Commissioning Groups[1], East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT), Sussex Community NHS Foundation Trust (SCFT), and Sussex Partnership NHS Foundation Trust (SPFT). We are a partnership of organisations working together to deliver health and social care in East Sussex. By breaking down barriers between health and social care, improving the health and wellbeing of local people, and reducing health inequalities we will deliver the right care and support, at the right time and in the right place for the people we serve.

Working with partners in primary care networks, district and borough councils, the voluntary and community sector and others, the plan sets out our longer term ambitions for our health and social care system in East Sussex, how we anticipate delivering this, and the work we will need to do collectively as a health and care system in the next year to improve the health and care of local people.

With advances in medicine and treatment, changing health and care needs, and new developments influencing wider society, we have to continually move forward so that in 10 years' time we have a health and care system that is fit for the future. In East Sussex the NHS and county council have been working closely together over recent years, alongside wider partners, to improve population health and wellbeing and reduce health inequalities, by breaking down barriers between health and social care to deliver the right services, in the right places, at the right time.

Thanks to this work we're seeing more treatment, care and support being delivered where people want it – in their own homes or locally in their community, by teams of GPs, nurses, therapists, social workers and proactive care practitioners from both the NHS and social care. This shift in the way we provide health and care means that many people are avoiding hospital altogether. And when they do need planned or urgent hospital care they're able to see clinicians and receive treatment more quickly and spend fewer unnecessary days in hospital, with better support when they go home. Here is a snapshot of some of our progress so far below:

- We have introduced the **award-winning i-Rock** services for young people in East Sussex (across Eastbourne, Hastings and Newhaven) who need help with mental health, wellbeing, housing, employment, education.
- We have trained local people to have over 5,000 'cancer conversations' with their fellow residents in Hastings and Bexhill, **to raise awareness of the signs and symptoms of cancer**, improve early diagnosis and help to save lives.
- We have introduced **Health and Social Care Connect** (HSCC) which is a fully integrated central point for health and adult social care enquiries, now available 24/7 for 365 days a year. This service helps people who are having difficulty taking care of themselves. The integrated service is able to arrange the immediate health attention required, as well as looking at home-based support that might be needed in the future.
- On-going development of **community health and social care services and initiatives**, including integrated health and social care teams, crisis response and proactive care, the Dementia Support Service; and the Joint Community Reablement Service and falls prevention services
- More information can be found on our Health and Social Care News website.

Building on these successes, this plan describes how we aim to further strengthen our work across the county through our East Sussex health and care programme to meet the needs of our population, including how we respond to our areas of deprivation and the significant older population that often have multiple-complex needs. By working in this joined-up way, we believe we're able to serve the whole of East Sussex even more effectively.

[1] Eastbourne, Hailsham and Seaford CCG; Hastings and Rother CCG; and High Weald Lewes Havens CCG

Our population

East Sussex has a population of approximately 555,000. Whilst it is well-known that it has amongst the highest proportions of over 65-year olds and over 85-year olds in the country, there are a range of other characteristics that are particular to East Sussex, as summarised below:

- 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 people with multiple conditions.
- There are inequalities within East Sussex in uptake of preventative services for example cancer screening.
- 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 special educational needs and disability (SEND) or Education Health and Care Plans some of whom will have complex medical and care needs.

There is growing demand on both NHS and social care services. More and more local people will require support and care for long term conditions. By joining up the care we provide we will be better able to support people to live as independently as possible and achieve the best possible health outcomes for them. In the long term, we need a 'new service model for the 21st Century'[1] to ensure that good quality health and care is available for everyone who needs it. This is outlined in our East Sussex Health and Care Plan which:

- Describes what we will do to drive the changes we need to make to meet the health and care needs of people living in East Sussex, reduce health inequalities and deliver longer term sustainability.
- Sets out some key local priorities (below) to work on together, where we think we can have a real impact through working collectively, informed by NHS Long Term Plan and the views of local people.

What we will do

During 2020/21 our key priorities are to:

- Build on our existing progress to enhance **prevention, personalisation and reduce health inequalities** and the gap in life expectancy in the county. We will do this through coordinated action across all services that impact on the wider determinants of health such as housing, employment and leisure, as well as extending targeted approaches to empower people to make healthy choices across the whole life course to improve outcomes.
- Improve existing support to **children and young people** focusing on improving mental health and emotional wellbeing; support for vulnerable young people at risk and looked

[1] NHS LTP (January 2019) and NHS LTP Implementation Framework (June 2019)

after children; support for children and young people with disabilities; and through health promotion activities.

- Within our **community services**, continue to integrate health and social care services; work with our primary care networks to further support people with long term conditions and those in care homes, including action to support people at the end of their lives.
- Continue action to improve support for people with **urgent care** needs including: targeted support for vulnerable people; improvements in urgent care processes and systems to deliver more streamlined care; support people in care homes with urgent care needs; and complete the introduction of our Integrated Urgent Care model, for example Urgent Treatment Centres.
- Further improve services that deliver **planned care** for local people including: better outpatient care through new technology and better organisation of services (e.g. one-stop clinics); supporting people with musculoskeletal, cardiac, diabetic, ophthalmic and cancer needs; review existing services to ensure evidence-based interventions are in place; action to improve waits for treatment where this is too long; and continue to support best practice with prescribing and medicines.
- Expand our support for people with **mental health** needs by establishing single point of access; enhanced support in the community to help avoid unnecessary admissions; and working with housing and voluntary sectors to support those people who also have housing related needs.

Our plans and priorities have been informed by what local people have recently told us is important to them about their health and care, and we will contiue to test our plans with our stakeholders to guide how people want to be involved in shaping the way we deliver our ambitions.

This integrated plan provides the foundation for our next steps as a health and social care partnership. Over the next 3-5 years we will build on this work together to further integrate care around our population's needs by working together across our system to further improve health and care for local people. We believe that this is the best and most sustainable approach, enabling us to make the best use of the resources available in our area to meet the challenges of rising demand and financial pressures, and ensure local people have access to the services and support they need.

Strengthening our ability to deliver

This integration is often called an **Integrated Care Partnership** (ICP), which will strengthen how we plan, organise and deliver services together in East Sussex, supported by a clear approach to our communities, and informed by their needs. We are currently developing proposals for an ICP which we plan to develop from April 2020.

We want to ensure that local people receive the right services, in the right place, at the right time. This may mean access to and use of services will be different in the future. We aim to empower local people with the knowledge of how to best use available health and social care services, and how to best get the support they need, and we believe this plan gives us the opportunity to deliver the improved health and care that our local people deserve.

1. East Sussex Health and Social Care Plan

1.1. Introduction and context

The Sussex Health and Care Partnership (SH&CP) 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"[2], and the transformation and integration plans that will need to be progressed to deliver this. The overarching submission is the Sussex Health and Care Strategy 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); 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 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 our strong history of integrated working in East Sussex, and builds on the progress we have made locally with priorities that we have been working on in 2019/20. Developed in partnership, the plan sets out how we will work together to address the commitments in the NHS LTP and 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 Sussex Health and Care Strategy

This plan reflects population health and social care needs in East Sussex, and the learning from our own local development work on our journey towards integration since 2014. We have looked at benchmarking tools such as Get It Right First Time, Right Care and Model Hospital, and a series of recent independent reviews that have helped us further understand the drivers of demand. This has enabled us to further consolidate our objectives to support improvements to the 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.
- On-going development of community health and social care services and initiatives, including integrated health and social care teams, crisis response and proactive care, the

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

Dementia Support Service; Health and Social Care Connect now available 24/7/365, and; the Joint Community Reablement Service and falls prevention services.
- Strong whole system performance against the Better Care Fund targets and the Care Quality Commission East Sussex 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, children and young people, community, urgent care, planned care and mental health** and how we will work more effectively together across our system, including primary care networks (PCNs), the voluntary and community sector (VCS) and district and borough councils and others to deliver a "new service model for the 21st century" 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 is 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 that also contributes to, and integrates with, the Sussex Health and Care Strategy.
- 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, fully taking 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, reduce health inequalities, and deliver outcomes on a sustainable basis.
- The arrangements for taking forward our Integrated Care Partnership including how we will work across our health and care system, the VCS and wider partners, to:
    - enable stronger coordination of health and care delivery to our population
    - make best use of our collective resources
    - shape our approach to integrated population health and social care commissioning 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.
- We will also further develop the 3-5 year system financial model that will need to underpin our plans for change.

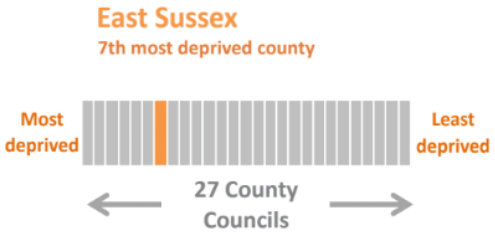
1.2. Our population health and social care needs

East Sussex is a county with contrasting characteristics across urban and rural communities. Health and its determinants are not distributed evenly across the county with a strong link between poverty and poor outcomes; although rurality can also have an impact on access to services. Overall, East Sussex is relatively deprived compared to other counties, but as figure 4 in Section

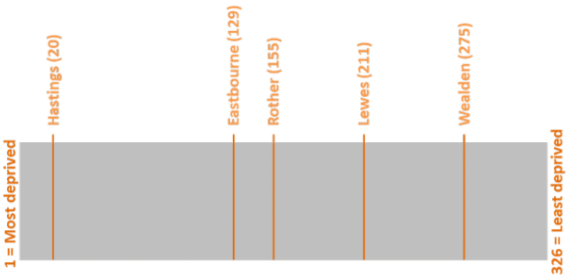
4.3 shows, there is significant variation in deprivation across the county and between primary care network populations which will result in differing health and social care needs. The proportion of people over 65 in East Sussex is considerably higher than nationally (26% vs 18%), and the proportion from Black and minority ethnic groups is smaller (8% vs 20%).

There are approximately 555,110 people living in the 1709 km^2 in East Sussex. In summary our population has the following characteristics:

Deprivation relatively high for a county…….and varies signficantly across East Sussex

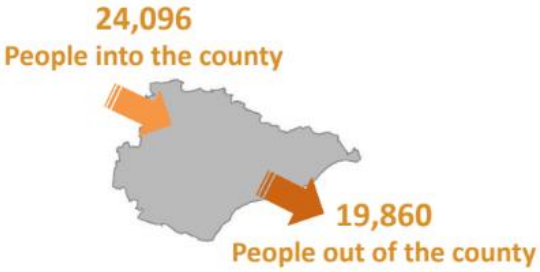


Deprivation By Lower Tier Local Authority, Index Of Multiple Deprivation, 2015

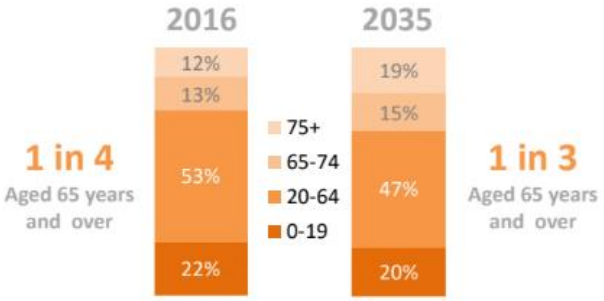


Most people live in urban areas

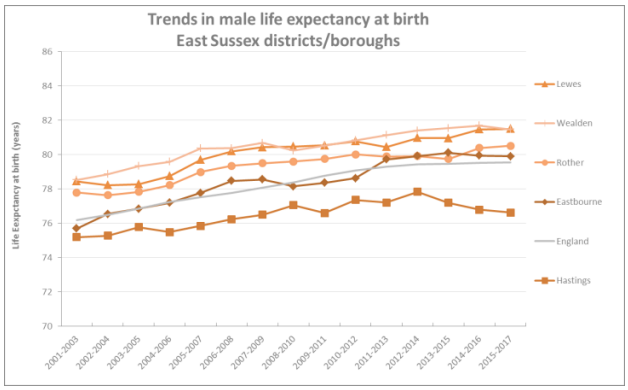
Our population is increasing….



..and getting older (more so than England)

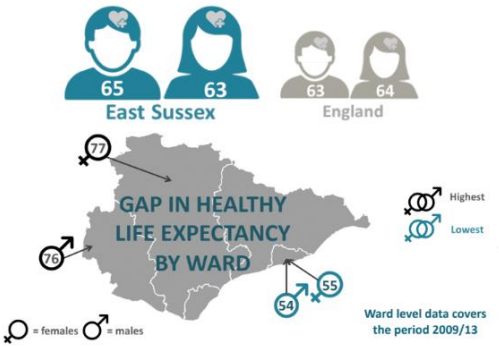


Like England, life expectancy is not increasing and has fallen for men in Hastings

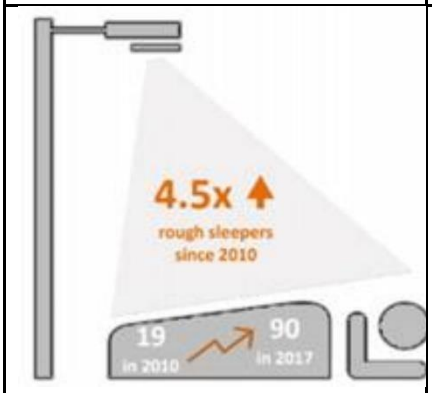
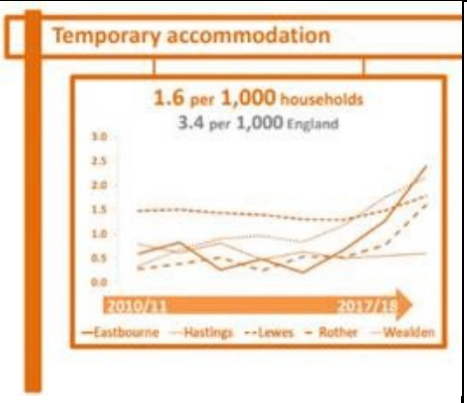


Illness and disability increase with age… ..but there are huge differences in when people become ill between wealthier and poorer areas

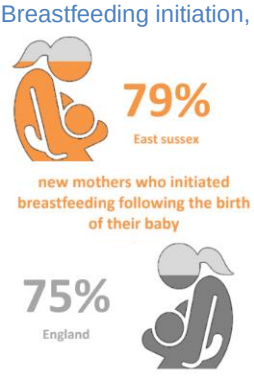
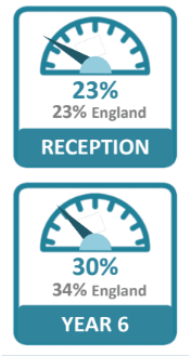
LONG TERM LIMITING ILLNESS OR DISABILITY, 2011



Housing needs - Access to a safe and secure place to live is a fundamental need for all people. Some of the most acute needs are increasing in East Sussex:

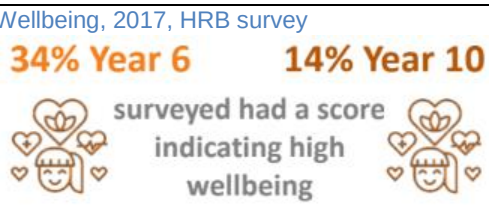
Rough sleepers increasing	Households in temporary accommodation increasing	Homeless households in priority need 2017/18
		

Best start in life, risk factors, chronic diseases and dementia

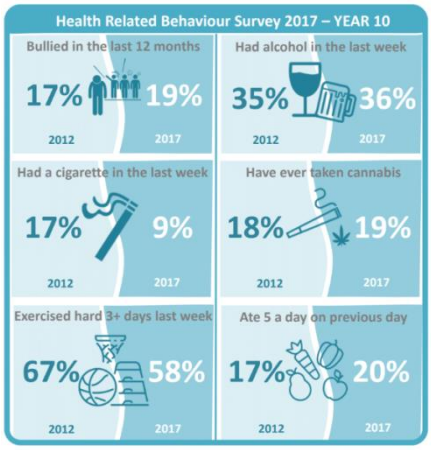
Smoking at time of delivery is higher than England	Breast-feeding intiation is higher than England	1 in 3 children age 10/11 are overweight or obese
		

Good school readiness

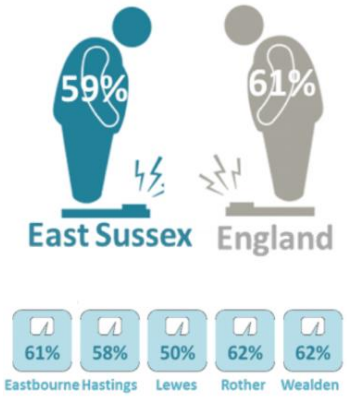
High wellbeing decreases between age 10-11 and age 14-15



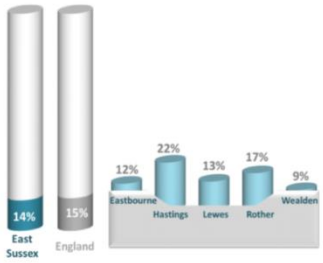
Some health-related behaviours in young people are improving, others getting worse



By adulthood almost 2 in 3 people are overweight or obese (varies by area)



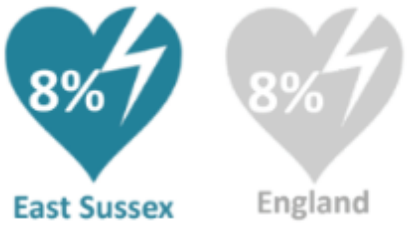
Smoking in adults varies by area



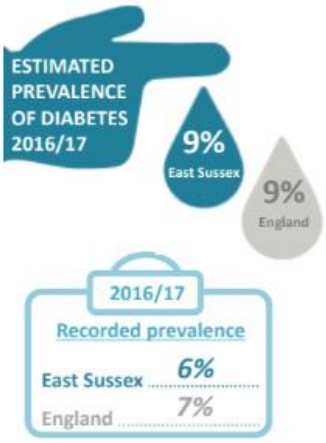
Over 1 in 4 adults in East Sussex drink too much alcohol

Over 1 in five adults are physically inactive

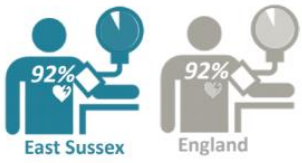
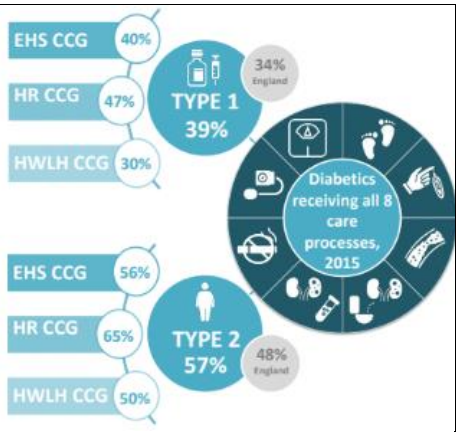
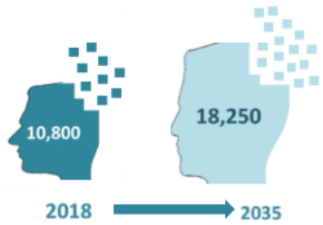
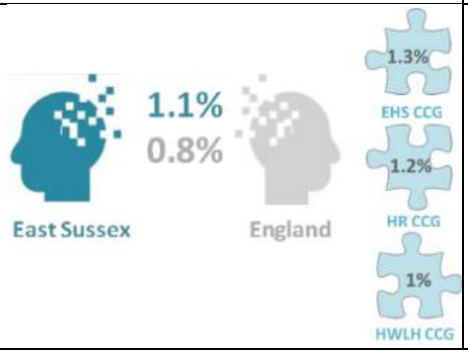
Chronic disease rates in East Sussex are similar to England:



Estimated Coronary Heart Disease (CHD) prevalence in 55-79 year olds, 2015



Diabetes

But there are variations in care between managing hypertension and managing diabetes	 **% of people with Coronary Heart Disease whose blood pressure is controlled 2016/17**	
Dementia cases predicted to increase as population ages	**Dementia rates higher than England (IGP recorded 2016/17).**	**1 in 3 cases of dementia could be prevented**
		

Causes of the gap in life expectancy

The biggest contributors to the inequalities in life expectancy in East Sussex are the same for men and women: circulatory disease, cancer and respiratory disease. Contributing preventable risk factors are smoking, poor air quality, alcohol, poor diet, and not enough physical activity. Social isolation is also known to result in reduced life expectancy.

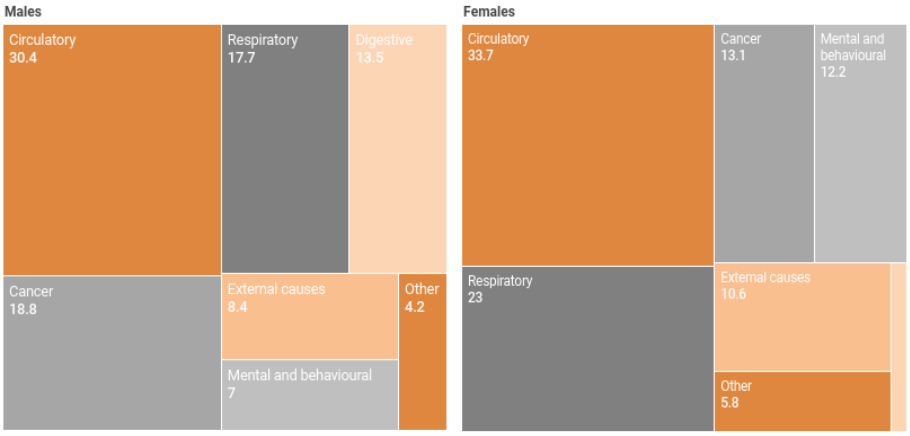


Figure 1 Causes of the gap in life expectancy between most and least deprived areas within East Sussex by gender

Key points

- 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.
- There are inequalities within East Sussex in uptake of preventative services e.g. cancer screening, immunisation and diabetes education programmes; other preventative services e.g. learning disability health checks have lower uptake in East Sussex (46%) compared to England (49%).

- 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.

In summary, East Sussex has among the highest proportions of over 65-year olds and over 85-year olds in the country, and within this many people live their later years in ill-health, often with more than one long term condition. There is growing demand on NHS and social care services as more and more people require support and care for long term conditions. Reducing health inequalities and the gap in life expectancy in the county also 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 their whole lives 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. We also need to get better at enabling people to stay fit and healthy for longer.

The advent of primary care networks (PCNs) with a focus from 2020/21 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 also 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, we believe 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 (figure 2) below gives a flavour of 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 some of the wider range of services and assets we have in our communities that impact on people's health and wellbeing.

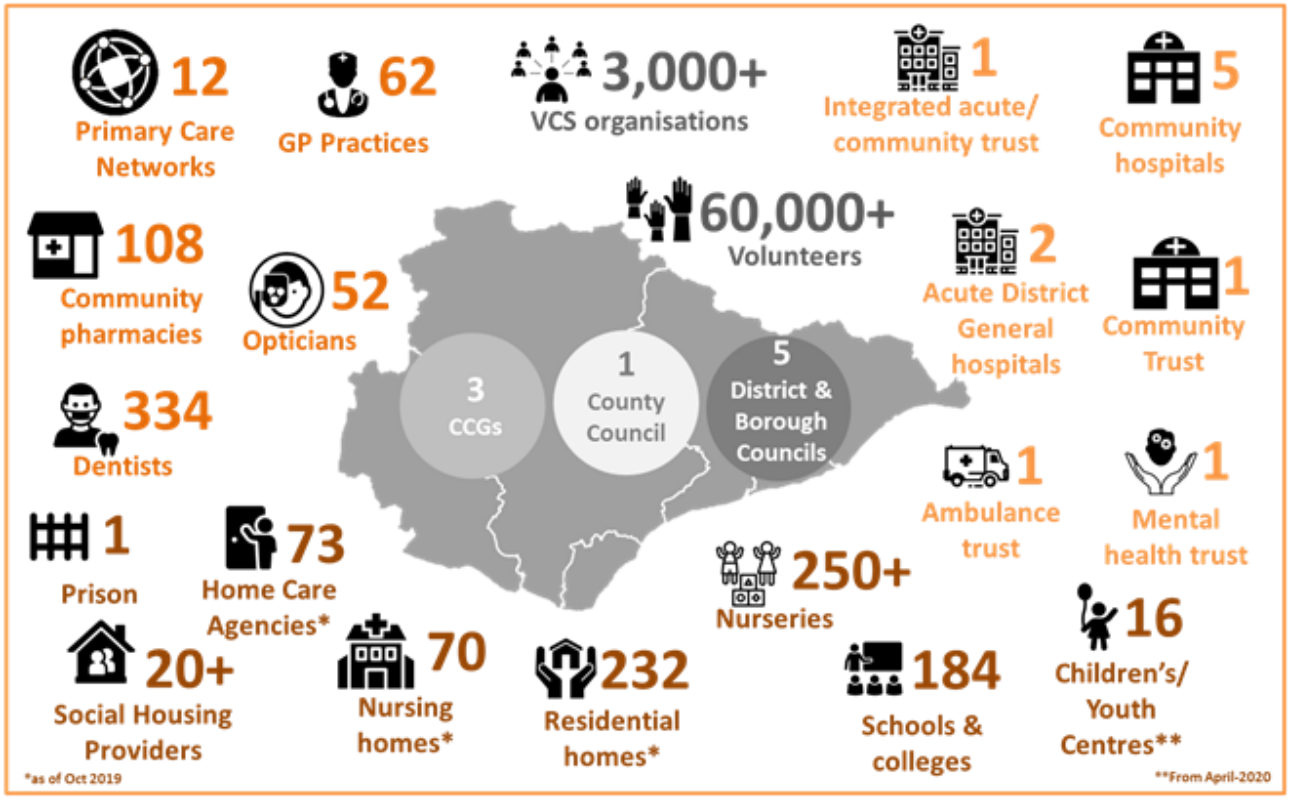


Figure 2 – a flavour of the organisations and networks in the East Sussex Health and Care System

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 healthcare providers and primary care networks, and other integrated care partnerships, sustainable transformation partnerships 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, the quality and experience of care, and 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). Moving forward in 2019/20 it has been agreed to bring these two programmes together to provide the foundation for a single East Sussex health and social care programme.

In summary, during the latter part of 2018/19 and early 2019/20 we have taken steps as a system to secure agreement to 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 SH&CP 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 SH&CP.
    - 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 reflect 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 SH&CP Sussex Health and Care Strategy, the plan strengthens the whole population focus across the East Sussex health and social care economy, as well as informing 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 anticipated plans for the next 3- 5 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 development of our East Sussex Integrated Care Partnership (ICP) to better support integrated delivery across our health and social care system, and integrated population health and care commissioning arrangements.

To underpin our plans we will also set out our understanding of our system financial model covering a three to five year period. This will set out the required shifts in investment to primary care and community health care, including meeting the new primary medical and community health services funding guarantee.

1.6. What we want to deliver

Informed by our local East Sussex County Council priorities[3] and NHS Long Term Plan[4,5] commitments, and engagement with our local communities, in the long term we expect to build on our integration work to date to deliver an integrated model of care with the following characteristics:

- A comprehensive approach to prevention, universal personal care and reducing health inequalities that cuts across our key clinical priorities and care pathways from enabling healthier behaviours and good wellbeing through to access to leisure, housing and other services that impact on the wider determinants of health, 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 across our health and care system, the VCS and others 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 reviews 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 primary care improved access in 2019/20 and 2020/21
    - Building the capacity, workforce and partnerships to do this
- Close system working between our East Sussex CCGs, ESCC, 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 support 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:
    - 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

[3] 'State of the County 2019, Focus on East Sussex' (July 2019), a copy can be found here
[4] NHS Long Term Plan (January 2019), a copy can be found here
[5] NHS Long Term Plan Implementation Framework(July 2019) a copy can be found here

- The continued implementation of our planned care programme including:
    - Driving efficiency and productivity in elective care pathways to reduce waiting lists
    - Enabling choice through expanding digital and online services
    - Transforming outpatients care and 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

The integrated model of care outlined above provides the foundation for the development of our proposals for implementing our East Sussex **Integrated Care Partnership** model. Our ICP will better enable delivery of these principles and priorities, as part of the wider development of the SH&CP into an **Integrated Care System.**

Through delivering this model we expect to better enable our system to deliver measurable improvements to the shared outcomes in our integrated Outcomes Framework. The integrated Outcomes Framework is a set of shared outcomes and measures developed in 2017, to support our collaboration and help us understand the impact of our work together as a health and social care system.

In 2019 we agreed to fully adopt this framework for our whole East Sussex population. We intend to refresh the framework to align with the East Sussex Health and Social Care Plan, and the supporting programmes of work. These outcomes have been developed with local people based on what matters to them about their health and social care services. Outcomes and measures are grouped together under the following four headings:

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 Long Term Plan 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 SH&CP Sussex Health and Care Strategy 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
- The evidence base arising from independent diagnostic work in 2018/19 on the drivers of our system deficit, and benchmarking tools such as Model Hospital, Get it Right First Time and NHS Rightcare

This has given us a set of key priorities we need to focus on as a system in 2020/21, as realistic and achievable next steps 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 for delivery in 2020/21, to be overseen by our Health and Wellbeing Board and supporting system partnership governance.

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 inititiaves 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 lengths of stay, as well as improved outcomes for people and their families.

Intervening at the earliest opportunity and preventing things from getting worse, as well as ensuring care is personalised, are all cross-cutting principles across our plan. We expect all new developments to consider opportunities for this as part of taking specific projects and initiatives forward.

Our overarching key priorities and the anticipated next steps we will take collectively in 2020/21 across prevention, children and young people, community, urgent care, planned care and mental health are summarised in the next section. Further detail about the background and approach in each area is set out in Appendices 1 – 6.

1.8. Summary of shared priorities for 2020/21

In this section we have set out our key areas of focus for 2020/21, to continue to drive the changes we need to see over the next 3-5 years. Further detail about the background and approach in each area can be found in Appendices 1 – 6.

1.8.1. Prevention personalisation and reducing health inequalities priorities

Priority	Next steps
Support with making healthier choices and action on health inequalities	• Implementing population health packs and working with primary care networks to explore popluation health management, risk stratification and target wider system partnership action across the broader determinants of health. • Work with SH&CP to use national guidance to set trajectories for narrowing inequalities in 2023/24 and 2028/29 to inform local wider system action planning • Specific partnership action to support healthier lifestyles and health inequalities; smoking, obesity and alocohol • Increasing screening and vaccinations programmes, tailoring our approach to areas of greatest need
Supporting self-care, self management and personalised care	• Begin to implement the NHS Comprehensive model of personalised care and the PCN Network Directed Enhanced Services (DES) contract requirements in 2020/21 • Ensuring opportunities for prevention, self-care, shared decision-making and personalised care planning and support are built into all pathway redesign priorities for planned care and end of life care • Review the patient activation measure pilot to inform further development of self care and and self management • Build on the rollout of wheelchair personal health budgets to identify further groups of people who may benefit from personal health budgets, for example people with continuing health needs
Social prescribing and community based support	• Implement an integrated social prescribing framework to reduce inequalities in health outcomes for local and diverse populations and improve mental health and wellbeing • Working closely with the voluntary and community sector align the PCN Network DES contract social prescribing investment with existing commissioned social prescribing commitments, such as the Community Connector Service, Primary Care Support Service and Carers prescriptions • Deliver an asset based wellbeing programme working with communities with poorer health and build strength-based solutions, adding to the range of support which social prescribers can signpost to
Preventing situations from getting worse	• Collaborate to begin to implement anticipatory care PCN network DES contract requirements from 2020/21 onwards, and link this with phased implementation of the target operating model for community health and social care services and multi-disciplinary care coordination working with primary care teams • Explore earlier intervention and targeting of falls prevention services at those who are at risk of a fall • Work with PCNs to help implement 'supporting carers in general practice - a framework of quality markers', and build on the Primary Care Support Service and Carers prescriptions, to ensure that better identification and support for carers in primary care is fully integrated into the new social prescribing link worker arrangements described above.

Improving outcomes for vulnerable and/or disadvantaged groups	• Widening access to physical health checks in primary care for people aged fourteenand over with a learning disability • Subject to the availability of funding continue to deliver initiatives to provide integrated support for rough sleepers • Commissioning housing related support services for those at risk of homelessness and support for carers • Support for vulnerable children and young people including action on County Lines and improving outcomes for children with special educational needs and disability (SEND)
Mental health and wellbeing	• Work towards of adopting the principles set out in the prevention concordat to enable a clear focus for cross sector action on better mental health for all • Build on and strengthen partnership work across the local NHS, social care, education, employment, housing, community resilience and cohesion, safety and justice and civil society, linking this with population health management approaches where possible

1.8.2. Children and Young People priorities

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 and other action to help address forthcoming recommendations of the Sussex-wide independent strategic review of the whole pathway of emotional wellbeing and mental health services for children and young people
Disability Pathways	Further develop our work around integrating the education, health, and social care needs of children and young people aged 0 – 25, aimed at producing local solutions, including: • integrated health and social care budgets for children with the highest complex needs • exploring a single assessment pathway for autism spectrum disorder and attention deficit hyperactivity disorder, and other neurodevelopmental disorders • improving early planning for children who transiton into adult health and social care services • reviewing mental health support for children and young people with autism
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 and review the service offer and needs for 18 – 25 year olds • Make strong links with the work taking place under the mental health and emotional wellbeing objectives
Universal Child Health Offer	• Ensure the provision of the Healthy Child Programme for under 5's through the Integrated Health Visiting and Children's Centres service • Support the delivery of the preventative health agenda through School Health Service. • Support nurseries, schools and hospitals to become health promoting settings

Looked after Children	• Ensure looked after children's needs are prioritised across health, social care and education to enable the best outcomes • Ensure mental health services are commissioned to optimise the emotional wellbeing of looked after children and previously looked after children

1.8.3. Community priorities

Implement Integrated Community Health and Social Care	• Continue to trial and roll out co-location to support joint working and care coordination for people with complex and multiple long term support needs • Progess a care coordination pilot for people with multiple long term condtions and support needs, including how to support enhanced case level collaboration with primary care, mental health and voluntary sector support services • Continue the wider rollout of home-based and bed-based Homefirst discharge pathways • Take forward therapy joint working to share skills, best practice and help create capacity • Consolidate the pilots and projects from Phase 1 of the community programme and begin to implement our agreed common target operating model to enable greater levels of multi-disciplinary working across primary medical care, community health, mental health and social care services. Strongly link and align this with: ○ PCN footprints to support effective multi-disciplinary working, including work to implement the PCN network DES contract for 2020/21 and risk stratification of local populations and proactive anticipatory care for those with multiple long-term conditions and/or assessed at high risk of unwarranted health outcomes ○ Developing further capacity in crisis response within two hours and reablement care within two days, noting the need to align the offer across the East Sussex footprint ○ Pathways for acute hospital-based care and discharge ○ Wider development and roll out of Enhanced Care in Care Homes
End of life care	• Ensure that End of life care strategies continue to be implemented to ensure the best end of life care for patients in the community working across primary and community health and social care teams and pathways, and in all settings of acute, secondary and primary care, hospices and care homes • Complete the case for change for anticipatory prescribing to meet the NICE Quality statement • Provide education opportunities for primary care • Link with other plans for supporting frailty and enhanced care in care homes and other community services as appropriate • Implement ReSPECT across acute, secondary and primary care providers and in hospices and care homes, to ensure personalised recommendations for a person's clinical care in a future emergency are taken account of

1.8.4. Urgent Care priorities

. High Intensity Users	• Further expand and focus on supporting patients with multiple needs with high numbers of A&E attendances and admissions

Ambulatory Emergency Care (AEC)	• Expansion of AEC at both 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	• Implement a range of initiatives to better support patients in care homes, build confidence for staff and avoid unnecessary admissions • Explore and develop how support can be delivered to people in care home settings in partnership with Primary Care Networks
Community Frailty/PEACE planning	• Further rollout of Proactive Elderly Advance Care (PEACE) planning as part of personalised care and support planning roll-out; supporting people in care homes
Integrated Urgent Care model	• Rollout of enhanced NHS 111 and Clinical Assessment Service from 1st April 2020 • Rollout of UTCs at Eastbourne DGH, Conquest Hospital, Hastings and Lewes Victoria Hospital • Further development of the Minor Injuries Units in Crowborough and Uckfield to improve local access for same day care • Direct booking into Primary Care Improved and Extended Access, UTCs or other walk in services and sites being developed as part of the East Sussex integrated urgent care model • Increased utilisation of Primary Care Improved Access capacity • Take forward further interventions in winter 2019/20 and 2020/21, as a result of recent diagnostic work on the drivers of demand for A&E services.

1.8.5. Planned Care priorities

Outpatients	• Introducing video appointments, virtual fracture clinics, electronic correspondence for our patients
	• Expanding of successful approaches to:
	  ○ improve the timeliness of treatment
	  ○ improve the experience of patients on care pathways
	  ○ reduce unnecessary appointments
	  ○ introduce one-stop clinics specifically focusing on gastroenterology and breast cancer two-week wait

Musculoskeletal Services	• Meet the growth in demand in a sustainable way by:
	  ○ Introducing First Contact Practitioners (FCPs) in GP surgeries designing the correct bespoke pathway to ensure timely recovery, minimised pain and improved independence
	  ○ Improving shared decision-making between specialist clinicians and patients with more complex conditions, alongside improved education on self-management
	  ○ Enabling patients to self-refer to physiotherapy so they start treatment earlier at the onset of a condition

Evidence Based Interventions	• Continue to review the latest evidence and change our recommended treatments where this evidence indicates areas that do not benefit our patients, allowing us to release capacity for the right treatments
Cardiology	• Work together to agree a new model of cardiology care spanning general practice through to community services and hospital care, that: ○ Increases identification of heart conditions and related support for patients to self-manage their own heart health ○ Reduces variation in community-based cardiology assessments by standardising pathways, enabling more patients to be treated within a community setting to make best use of capacity ○ Supports the long term sustainability of hospital services
Diabetes	• Build on our success in implementing complex diabetes treatment in a community setting, and our expansion of urgent treatment for diabetics to: ○ Provide improved patient experience for people with diabetes by reducing unnecessary hospital appointments including outpatient appointments and hospital admissions ○ Provide improved access for psychological therapies for people living with diabetes that also have co-morbid depression/anxiety ○ Provide improved access to innovative technologies for glucose monitoring for patients with type 1 diabetes (includes flash and continuous glucose monitoring). • Develop a system plan to manage the predicted exponential growth in diabetes over the next 3 years.
Ophthalmology	• Work closely with acute and community providers to ensure a seamless pathway, focussing on addressing the growing demand by repatriating care to our specialist community optometrists, releasing capacity in our hospital multidisciplinary teams to manage the more complex eye conditions.
26-week wait and capacity alerts	• Implement a planned choice process for all patients who reach a 26-week wait, starting in areas with the longest waits, to give patients options to access care across NHS services in Sussex
Cancer	• During 2020/21 we will build on existing work to take forward local plans in the following areas: ○ Continue to improve performance against the cancer constitutional waiting times standards and ensure sustainability, including the new 28 day faster diagnosis standard ○ Improve the uptake of screening targeting those areas with lower uptake and focus on inequalities ○ Strengthen the two-week wait process to ensure referrals are managed proactively ○ Implement personalised care pathways for breast cancer and develop plans for other specialties, with prostate and colorectal as priorities

Medicines optimisation	• Use NHS England-led programmes to optimise prescribing in a range of areas including diabetes, pain management, malnutrition and anticoagulation; and de-prescribing medicines no longer needed • Develop an Integrated Medicines Optimisation services and approaches between local Primary care Networks (PCNs) and local NHS Trust providers, to support the delivery of structured medication reviews and quality improvement • Continue the medicines optimisation in care homes service and work towards integration with the PCN structured medicines review and optimisation service, under the PCN Network Directed Enhanced Services (DES) contract in 2020/21 • Rollout the electronic transfer of medicines discharge information between hospital and community pharmacists; and implementation of a quality improvement process for pharmacy led interventions • Provide integrated vocational training programmes for pharmacists and pharmacy technicians across primary and secondary care, mental health and community services

1.8.6. Mental Health priorities

Single point of access - no 'wrong doors' and access to crisis pathways	• Expansion of NHS 111 so that it can take mental health referrals • Pilot a Single Point of Access (SPOA) for adults embedded within Health and Social Care Connect. • Simplify pathways to support joint working across mental health and social care teams
Community health and social care teams for adults with severe mental health issues	• Enhance integrated working through pathways, protocol development in relation to Approved Mental Health Professional duties, and access to crisis resolution and home treatment (CHRT) teams to help avoid unnecessary admissions • Link with phased development of the target operating model for community health and social are services, to deliver a more integrated and multi-disciplinary approach to meeting physical health and mental health needs
Supported Accommodation pathways	• Deliver the review of supported accommodation pathways to inform work with housing teams to find long term solutions and take forward recommendations
Rough Sleeping	• Pursue opportunities to bid for further funding post March 2020 from the Ministry of Housing, Communities and Local Government, to continue initiatives
Aftercare and support	• Further develop joint leadership to support safe and timely discharge and coordination of care plans.
Access to children and young people's MH services	• Implement the recommendations of the Sussex-wide independent strategic review of the whole pathway of emotional wellbeing and mental health services for children and young people

2. Summary roadmap

The high level milestones for the next five years are as follows:

When by	Milestone
August – November 2019	• East Sussex Health and Social Care Plan developed and finalised. • Submission of SH&CP Health and Care Strategy to NHS England.
December 2019	• Health and Wellbeing Board endorses East Sussex Health and Social Care Plan
January 2020	• Further implementation planning for delivey in 2020/21, including: ○ Further refinement of priority-setting, programme objectives and KPIs ○ Integrated outcomes framework refresh ○ Further testing with local system and stakeholders ○ Further development of proposals for our East Sussex ICP and population health and care commissioning
March 2020	• East Sussex Clinical Commissioning Groups merger process complete, subject to application and approval by NHS England • Agree proposals for our East Sussex Integrated Care Partnership • Agree proposals for our approach to integrated population health and care commissioning in East Sussex.
April 2020 – March 2021	• Delivery of 2020/21 transformation programme and LTP priorities. • Begin delivery (as per agreed proposals) of: ○ East Sussex Integrated Care Partnership ○ East Sussex Population Health and Care Commissioning ○ Next wave of PCN Network Contract DES requirements ○ Phase one of target operating model for community health and social care services • Continued financial stabilisation of system.
April 2021 – March 2022	• East Sussex Integrated Care Partnership in place • East Sussex Population Health and Care Commissioning in place. • Sussex Health and Care Integrated Care System in place. • Continued financial stabilisation of system
April 2022 – March 2023	• Further consolidation of our Integrated Care Partnership and population health and care commissioning arrangements • Continued financial stabilisation of system
April 2023 – March 2024	• Continued financial stabilisation of system. • Primary medical and community health service funding guarantee met.

3. Our approach to engaging with our stakeholders

3.1. Background

A comprehensive approach to engagement with local people (including 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.

Our overall strategy has been guided and supported by our joint 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. Moving forward a communications and engagement strategy will be produced to support the delivery of the East Sussex Plan.

Our approach has also been underpinned by the development an integrated outcomes framework in 2017/18, based on what is important to local people about their health and care. This is collectively owned and shared across our health and social care system. We aim to refresh our 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 SH&CP's wide ranging public engagement exercise about the NHS Long Term Plan during the Spring of 2019, 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. Equalities and diversity

The East Sussex Health and Social Care Partnership is fully committed to ensuring the improvement of the health and wellbeing of all our population and we will commission services in a way that enables us to take account of this. Recognising the high level nature of this plan, we will ensure that all of our projects and initiatives take account of our diverse population as we move towards implementation and delivery, including protected characteristics, as detailed in the Equalities Act.

In particular we expect to drive this forward through the ongoing implementation of personalised care that is designed take account of individual circumstances, differences and strengths. In addition we will ensure that diverse and seldom heard groups and communities are a key focus in the communications and engagement strategy that we will develop to support this plan, and the specific projects and developments within it. For example, through reaching out to parts of the community who may not traditionally get involved in our work, such as working age people, young people (16+), equalities groups and communities, and neighbourhood groups (with a focus on rural communities and areas of deprivation).

We are also undertaking a high level joint Equalities and Health Inequalities Impact Assessment (EHIA) screening 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 also inform the framework for continuous engagement with all of our stakeholders.

3.3 How we have used insight and key themes from recent engagement

A multi-agency East Sussex Plan Task Group was set up with nominated leads across our system, including representation from Healthwatch and the voluntary and community sector, to work together to guide and shape the development of the East Sussex Health and Social Care Plan.

An audit of existing insight from recent engagement events and exercises was undertaken to provide a snapshot of the key themes across East Sussex to help inform our plan, alongside our benchmarking. This included reviewing the East Sussex insight from the Phase 1 report from the Big Health and Care Conversation and Our Health and Care, Our Future[6] engagement on the NHS LTP (insight from Phase 2 will be added when available), as well as from the joint Shaping Health and Care events that were specific to East Sussex. The Adult Social Care and Health Listening to You survey, and the Children and Young People's Takeover Day 2018 , which focussed on mental health and wellbeing were also reviewed. A summary of the key themes is contained in Apppendix 7 grouped under the following headings:

- Joining up health and care services, partnership working and collaboration
- Communication, access to information and information sharing
- Digital
- Staffing resources and funding
- The role of the community sector, and social prescribing
- Health inequalities
- Prevention and supporting healthier choices
- Mental health
- Holistic and personal care
- Access to services and experience of services
- End of life care
- Multiple and complex needs

The themes from the audit have been used to help inform our ambitions for our longer term health and social care model (described in section 1.6), and have helped shape the priorities and next steps that we anticipate will enable progress in 2020/21 and onwards. The themes will continue to be used to inform next phase of planning for delivery, alongside more bespoke engagement.

The themes from the audit will also be used to support the refresh of our integrated outcomes framework for 2020/21 and ensuring it continues to reflect what matters to local people about their health and social care services.

3.4. Next steps – informing ongoing planning and implementation

Building on the comprehensive approaches to engagement undertaken to date, our priorities and

[6] The Our Health, Our Care, Our Future engagement was undertaken in two phases across Sussex. Phase one focused on a series of events where local stakeholders and the public were invited to share their views to inform our work; phase two focused on reaching out to parts of the community who may not traditionally get invovled in our work, for example working age people – including NHS staff, young people (16+), equalities groups and communities, and neighbourhood groups (with a focus on rural communities and areas of deprivation)

next steps for transformation and integration will be used to create a framework of continuous engagement with our stakeholders. A system communications and engagement strategy will be developed to support this.

We will continue to test our plans with our broad base of local stakeholders who are regularly in touch with us about developments. This will be done both through existing mechanisms such as the Patient Participation Groups Forum, the East Sussex Seniors Association (ESSA), and the East Sussex Inclusion Advisory Group (IAG), as well as new forms of engagement designed to reach people less likely to get involved, as they emerge.

Our system partnership governance has also been reviewed and has evolved and we have launched a new East Sussex Health and Social Care System Partnership Board, to ensure a broader system partnership to lead and oversee delivery of our plans, and development of our integrated care partnership proposals on behalf of the Health and Wellbeing Board. We will achieve this through aligning organisational plans across our health, social care and wellbeing system, involving all key stakeholders and taking action together. 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 specifically. 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, by building on existing skills and knowledge and developing much better ways of working for the benefit of people in East Sussex. A joint planning group has been formed to identify community priorities, using our collective knowledge and data and move swiftly to 'doing' – taking action on the wider determinants of health as well as the role of the VCS in delivering health and care services and support.

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. This 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 social care needs of our population
- Improve the health of or 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 plans, through aligning organisational plans across our health, social care and wellbeing system.

In order to do this effectively the new 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.

The structure below shows the current key elements of our partnership governance and the lines of accountability. It will be kept under review and will evolve over time, for example, as our East Sussex Integrated Care Partnership (ICP – see section 4.2 below) and broader system working take shape.

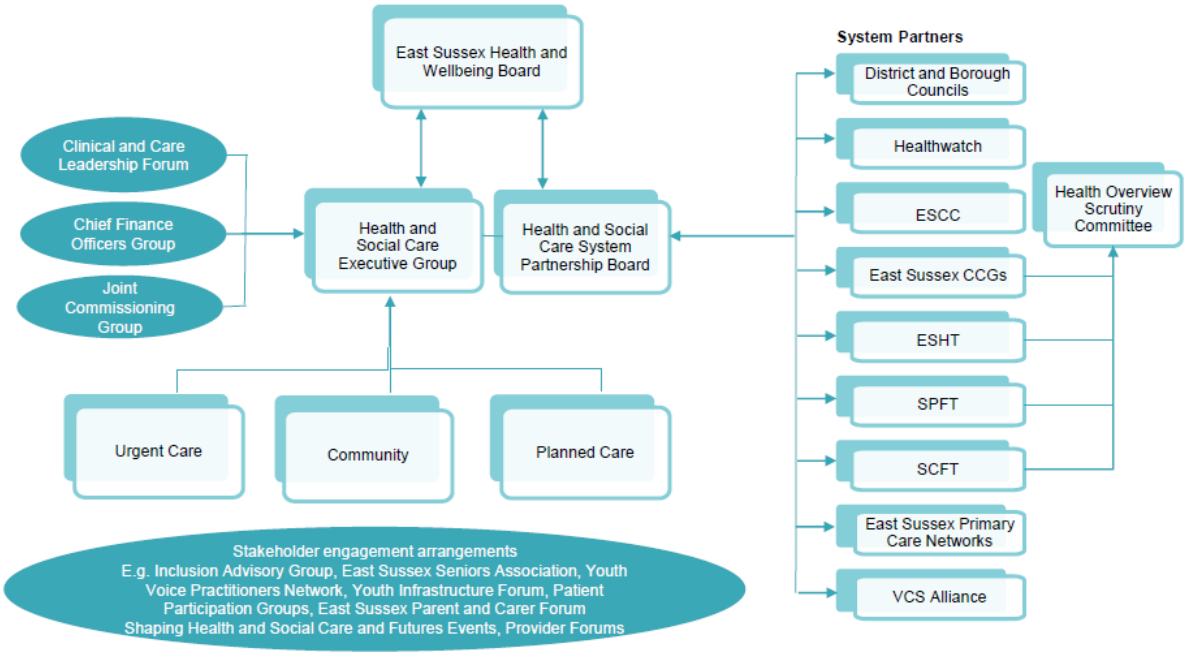


Figure 3: Key elements of partnership governance

4.2. Developing our integrated care partnership

Part of the work of the System Partnership Board will involve ensuring proposals are developed and implemented for 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 all providers of primary, community, mental health and social care with consistent pathways into and out of hospital care when this is needed.

This includes ensuring there are strong links with services that have an impact on the broader determinants of health, for example those provided by district and borough councils and VCS services and support, 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, acute hospital services provided within Sussex and Kent, and specialist services within Sussex and beyond.

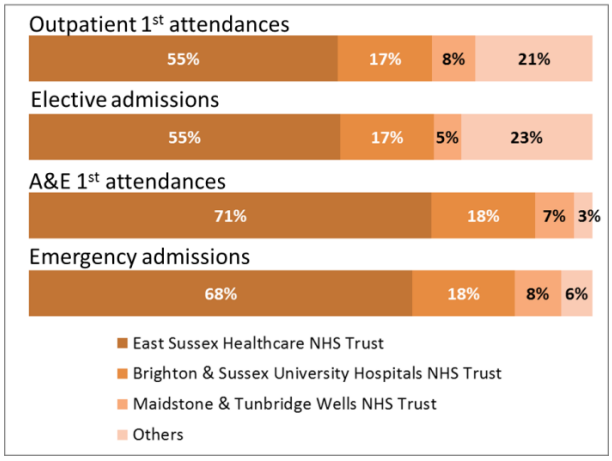


Figure 4: Hospital activity by provider for East Sussex residents in 2017/18
Source: Hospital Episode Statistics

The majority of East Sussex residents access services within the county, particularly for urgent care.

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 and 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 (PCN) development

There are 12 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 further delivery of primary care improved access is under way. An opportunity for PCNs to increase the pace of their partnership working has also been provided through the local offer of a PCN accelerator programme. Four specific areas of focus have been identified, for PCNs to accelerate and respond to the challenges and focus on:

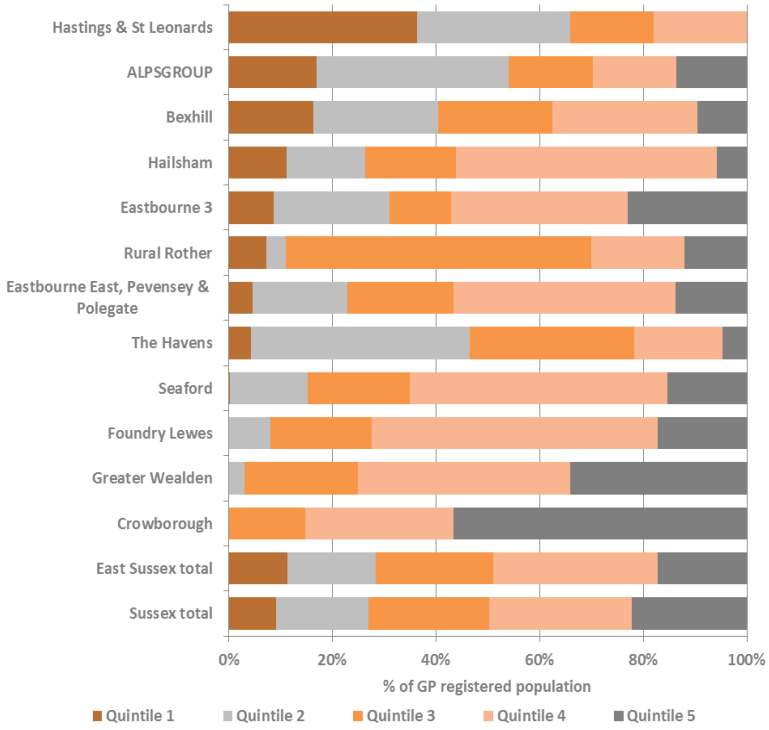
- The development and acceleration of a PCN to progress at pace, mature and deliver their ambition
- Delivery of the Sussex STP Clinical Variation Programme ambitions and requirements (Musculoskeletal falls, Diabetes, and Cardiovascular disease)
- Responses to the requirements of the LTP (including anticipatory 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. Poor health outcomes and the need for services are strongly associated with deprivation. Figure 4 illustrates the variation in deprivation profiles between PCNs – in Hastings and St Leonards over 30% of patients live in the nationally most deprived quintile, where as in Crowborough, over 50% of patients live in the least deprived quintile. 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.

Figure 5 – Primary Care networks by national deprivation quintile 1 = most deprived



There is a place for collective representation of the East Sussex PCNs on the new Health and Social Care System Partnership Board (SPB), 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 implentation 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 to develop 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 an individual PCN-basis. The diabetes prevention LCS will support 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.

4.4 Our shared financial model

We are working to set out a description of our system 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.

There is Sussex-wide work on financial modelling which will inform the local model for East Sussex

and how we will narrow any gaps by 2023/24, as well as meet the required shifts. The work on the East Sussex system will link through to our priority programmes of work and will seek to take a whole East Sussex health and social care economy approach. This will also support operational and business plans for 2020/21 as the detail develops.

4.5 Managing shared risks

Key risks to this plan will be considered in detail as part of the next phase of planning to support delivery. Shared system risks will then be and logged and managed as part of our programme monitoring arrangements. At a high level our key shared risks to delivering the plan, and the new model of care overall, centre around recruitment and retention of our workforce, for example the potential impacts of introducing new roles in primary care, our system financial position, and capacity in our independent care sector market[7].

As outlined in this plan, through taking a more collaborative approach to recruitment and organisational development, and decisions about our collective resources and commissioning, we can have positive impacts on these areas to help manage these risks.

5. Supporting our system to deliver our plans

5.1. Our workforce

5.1.2. 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 a 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).

The 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 PCNs and their workforce plans. For example, this will take the form of workforce planning and workforce

[7] 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

information resources at Sussex Training Hub level to provide a consistent approach to workforce planning in primary care.

5.1.3. 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, they are the people who can make a success of system-wide transformation as well as being 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 vital as each is integral to becoming a high performing system in East Sussex. 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.

5.1.4. 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.

5.1.5. 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

5.1.6. 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, Health Education England Kent Surrey Sussex (HEE KSS) has previously provided operational plan funding which was combined with GP Forward View 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 SH&CP to support the following identified priorities to help address the workforce issues within primary care:

- GP retention schemes funded via NHSE and SH&CP,
- Creation of educational incentive scheme/hubs to increase training within GP practices where this is currently lacking,
- Support for PCNs with developing workforce plans (as per the NHS LTP),
- Continued support to practices introducing care navigation.
- Support social prescribing implementation and ensure 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 deliver 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 the 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 described here from the a person-centred perspective:

- **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 -** I do 'not have to attend outpatients unless I'm required to do so' by deploying remote care alternatives to traditional outpatient appointments.
- **Ourpersonalised 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 to access their health record through a single online identity. 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 people 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, improving 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	• Access to manage care • Long term conditions – telehealth and devices • Patients hold their care plan	Our Personalised Health	• PHR in cancer, diabetes and beyond online consultations. • Portals in social care. • Improve digital inclusion in our population. • Rationalisation of local service directories across CCG and Social care. • Integrating with the NHS App.

LTP	Priority	Themes	East Sussex initiatives
Supporting health and care professionals	• More satisfying place to work – more effective tools • Increasing pace to out of hospital based care	Our Direct Care	• Integrated Care Record allowing professionals a better view of the person they are caring for. • Supporting teams integrated across health and social care to better work together. • Smarter Working and Agile Practitioner – how technology can be harnessed to support more flexible and effective working practices. • 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).
Supporting clinical care	• Technologies enabling pathway re-design • Co-production between patients, clinicians and carers	Our Direct Care, Our Personalised Health, Our Population Insight	• 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. • Integrating use of digital across services, removing barriers to sharing care information between providers, and between our population and the practitioners delivering their 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	• Population insight to understand greatest health • Provide evidence to	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.

LTP	Priority	Themes	East Sussex initiatives
	improve the way we change		
Improving clinical efficiency and safety	• Improving ways of working between practitioners, to allow more effective integrated working	Our 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 PCNs. 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 local GPs to assess the suitability of the 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 being 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 PCNs 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 PCNs 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

While it is acknowledged that ESHT and SCFT have areas of concern around the level of investment required to address the estates maintenance backlog, medical equipment and IT challenges, we are developing an ambitious programme to address these matters. The 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 (UTCs). This sits alongside significant investment within the hospitals on backlog maintenance and infrastructure, medical equipment and digital capability. Working with and through the SH&CP 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 a single assessment unit/UTC at Conquest Hospital (£6.28m) and the development of the UTC at Eastbourne DGH (£3.78m). N.B. this is wider investment around the 'front door' and doesn't preclude delivery of the UTC model by December 2019.

Through the development of the SH&CP 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 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 Teatement Centre at Lewes Victoria Hospital, enabling an enhanced offer for local people in line with our Integrated Urgent Care strategy. The minor injuries unit (MIU) at Lewes Victoria Hospital closed temporarily on 6 November 2019 to allow improvement works to upgrade it to a UTC to start. This work is scheduled to be completed by April 2020.

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 primary care improved access), IC24, and the recently formed PCNs.

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

- Distribution of beds to ensure safer staffing, cohorting and to improve system flows (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 the 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 enable 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, particulary leisure.

Appendix 1
Prevention, personalisation and reducing health inequalities – programme summary

1. Background

In East Sussex we recognise that to fully realise the benefits of prevention, early intervention and personalisation for improving health and wellbeing and reducing health inequalities, our approach needs to be embedded throughout our health and care system and delivered in communities through working with voluntary and community sector partners, civic interventions and clinical and integrated care services.

There are general duties under the **Care Act 2014** to prevent, reduce or delay needs for care and support, including carers. Our local approach also fits with the NHS Long Term Plan (LTP) aims of supporting people to live longer, healthier lives through helping to make healthier choices easier, and treating avoidable illness early on.

To achieve this involves strong multi-agency working by providers of care and support in all settings. Our clinicians, care professionals, staff and volunteers across all services will be supported to make the most of the contact we have with clients and patients in a wide variety of settings, including when people have been admitted to hospital, to help people to improve their health and wellbeing. For example our training programme **Make Every Contact Count** is currently being rolled out to staff working in our health and care system, so that they know how to encourage changes in behaviours that have a positive effect on the health and wellbeing of individuals, communities and populations, and where best to signpost or refer people for support with improving health.

The diagram below illustrates three different ways that our East Sussex place can deliver prevention and reduce inequalities, in line with the specific needs of our local communities. This also draws out where a more standardised approach to some services across the Sussex Health and Care Partnership (SH&CP - our STP and emergent Integrated Care System) footprint will also strengthen impact across our shared population. Our approach will enable help where it is most needed in communities and population groups, and reflecting the real-life context of people's lives, in order to reduce the inequalities in health outcomes which exist within East Sussex.

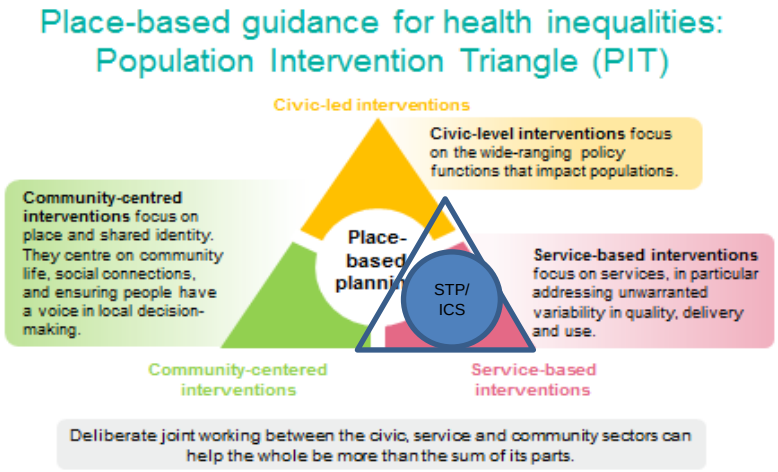


Figure 1 Place-based approaches to reducing inequalities and illustration of ICS main sphere of influence From PHE Addressing Health Inequalities Webinar (09.08.2019)

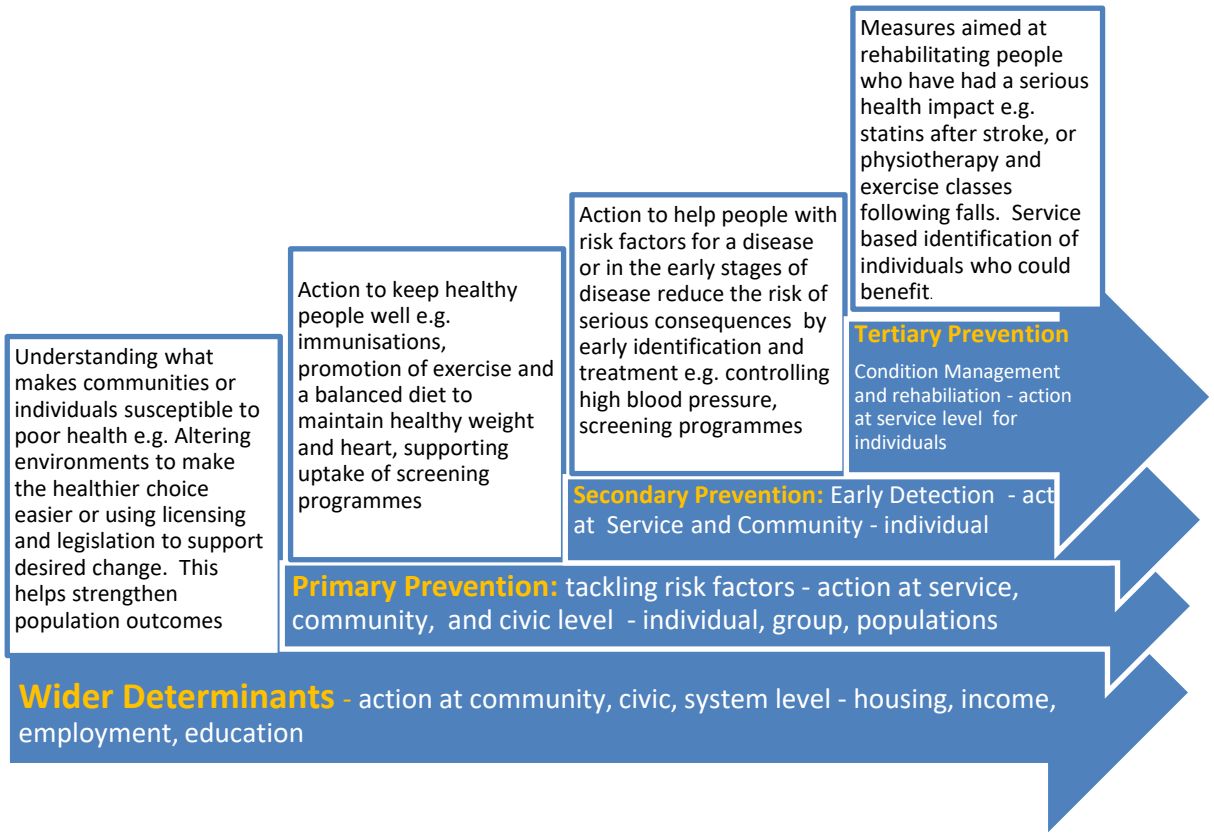
Our approach to prevention to date has ensured that it is embedded into the whole care across the life-course pathway, and covers:

- Giving every child the best start in life and supporting people to maintain good health and promoting healthy choices

- Helping people to help themselves and putting people more in control of long-term conditions through supporting greater levels of self-care, self-management and personalisation for example, through shared decision-making and personal health budgets
- Intervening early and proactively to prevent conditions and situations from getting worse, helping avoid unnecessary hospital admissions through stronger community pathways and support
- Enabling fast discharge to community environments where patients can be rehabilitated back to more independent living after an episode or spell in hospital.

This requires coordinated action by a range of partners and services from those that impact on the wider determinants of health, through to coordinated multi-disciplinary team work across primary, community, mental health and social care. Figure 2 gives a flavour of the four different levels of prevention.

Figure 2 - Definitions of prevention adapted from NHS England Population Health Management Flatpack



Our past work through ESBT and Connecting 4 You provides a strong foundation for work on prevention, personalisation and reducing health inequalities through ensuring we have a comprehensive and coordinated range of preventative services across all four levels of prevention. This includes:

- Commissioning the **Healthy Child Programme** – the 0-5 service is jointly delivered by health visitors, children's centre staff and family keyworkers, with the 5-19 healthy child programme delivered through the school health service.
- Supporting nurseries, schools and hospitals to become health promoting settings.
- Introduction of **One You East Sussex**, an integrated lifestyle service, which delivers individual behaviour change support.

- A longstanding approach to involving and supporting the active participation of people over 50, through our work with over 6,000 older people in the East Sussex Seniors Association (ESSA) and the seven member forums. Our established annual **UK Older People's Day** celebrations, now in its 12th year, provides an opportunity to promote a coordinated range of activities to promote healthy ageing, including opportunities for increasing exercise, reducing social isolation, and increasing participation in community activities.
- Providing **Making Every Contact Count (MECC)** training to health, social care, housing and voluntary and community sector staff and volunteers.
- Support for vulnerable people living in cold homes delivered by our **Warm Home Check Service**.
- **Healthy Hastings and Rother**, which aims to reduce health inequalities in our most disadvantaged communities. In order to find out more about the programme, which was launched in 2014, and its achievements, see: www.hastingsandrotherccg.nhs.uk/your-health/healthyhastingsandrother/
- As acknowledged by the Care Quality Commission (CQC), supporting our well-established voluntary and community sector in East Sussex to work with system partners to develop a number of services to help people to stay in their own homes.[8]
- In keeping with the above, our approach to investing in voluntary and community organisations in East Sussex helps to ensure that their critical role in supporting prevention, personalisation and reducing health inequalities, is recognised and supported to deliver outcomes. For example, **Take Home and Settle** and **Home from Hospital** services helping avoid hospital admissions and supporting hospital discharge pathways; **Supporting People** services; services and support for carers; the development of **Good Neighbour Schemes**, and; supper clubs for people living with dementia and their carers.
- Joint working through key partnership programmes such as **personal resilience** and **community resilience** to ensure a systematic approach to working with the strengths and assets in our communities across the county.
- Piloting the Patient Activation Measure (PAM) to help target support with self-care and self-management.
- Including **prevention and early intervention** in the diabetes care pathway redesign through GP-led multidisciplinary community teams as well as supporting greater levels of patient involvement in decision-making and self-care within care pathway
- Trialing **proactive care and assessments on frailty** as a feature of core health and social care pathways to identify and target support
- **Falls prevention services** provided jointly by our Joint Community Rehabilitation team and local leisure trusts Wave Leisure and Freedom Leisure, offering rehabilitation and reablement to adults within their own homes or community settings including equipment, exercise and mobility. Fracture liaison services are also provided for people who have had a fragility fracture, and targeted support is also provided to care homes offering risk assessment and management, training and falls monitoring and support to reduce risks for individual residents.

2. What do we want to achieve

Our aim is to promote, maintain and enhance people's wellbeing and independence in their communities so they are healthier, more resilient and are ultimately less likely to need formal health and social care services. We call this early intervention and prevention.

The overall outcomes we wish to achieve are:

- Improved population health and wellbeing
- Good communication and access to information for local people

[8] Care Quality Commission Local System Review of East Sussex (November 2017), page 28 https://www.cqc.org.uk/sites/default/files/20180126_east_sussex_local_system_review_report.pdf

- Sustainable services for the future
- Improved experience and quality of care and support

In order to do this, we will be seeking to continue our work with partners to support preventative interventions and commission services and support that:

- Use community-centred and asset based approaches that involve and empower individuals, schools and local communities to actively participate and take action on improving community health and wellbeing, providing appropriate help for mental or physical health problems at the earliest point and reducing health inequalities.
- Provide holistic integrated services based around the needs of children, young people and adults with disabilities enabling local solutions to our residents' needs.
- Provide support for people with long term conditions and support needs, and their carers and families to feel in control and independent, for example through personal health budgets and integrated care budgets, self-care and self-management techniques, and social prescribing to put people in touch with wider support and services available in communities to maximise their independence.
- Encourage people to take a more active role in maintaining and improving their own health, and support families and communities to stay as healthy and independent as possible.
- Support adults reaching, or at, a point of crisis by providing short-term outcomes-based support that enables them to regain their independence after the crisis has passed.

Impacts and savings from prevention are difficult to quantify precisely, with the time scale varying from a few months to many years. In addition, impacts are often accrued across the whole system, for example savings from reducing harmful alcohol consumption has an impact across a whole range of services including the police, social services and the health service, but are commissioned by local authorities.

We will continue to use the evidence base provided by tools such as the Public Health England Health Economics Evidence Resource and NICE Guidance, and our local business case development processes as appropriate, to guide how we can get the most impact and benefit for local people from all of our prevention interventions. We will also continue to measure whether we're improving health and wellbeing overall through our integrated Outcomes Framework.

3. Key priorities for 2020/21

The role of primary care and the twelve new **Primary Care Networks (PCNs)** in East Sussex will help us build on the comprehensive approach to prevention developed in recent years, and further consolidate it. Launched in July 2019, the PCNs bring together GPs to work together collectively and with other providers such as community health and social care services, mental health, pharmacies and voluntary organisations, to deliver certain services in a more integrated way for their patients and populations. This will enable people to experience well-planned services, appropriate to their needs, and seamless pathways.

Since July 2019, the continued implementation of primary care improved access and social prescribing link worker roles has been taken forward, with funding via the new PCN Network Directed Enhanced Services (DES) contract. Seven new service specifications will be published to build on this, presenting new opportunities to better understand the needs and assets of local communities, as well as individual strengths and risks, and tailor our collective resources to meet health and care need.

Timescale	Network DES contract specification
2020/21	• Structured Medicines Review and Optimisation • Enhanced care in care homes

2020/21 onwards	• Anticipatory care requirements • Personalised Care • Supporting Early Cancer diagnosis
2021/22 onwards	• CVD Prevention and Diagnosis • Tackling neighbourhood Inequalities

Through collaborating as partners across our system to support the delivery of these specifications, we will consolidate our learning and progress made to date in these areas, to strengthen our overall approach to prevention, personalisation and reducing health inequalities in our communities.

Our approach to prevention and early intervention is also **cross-cutting**, which means that it needs to align with the other priorities in our East Sussex plan, so that approaches to prevention, early intervention, personalisation and opportunities to reduce health inequalities are fully embedded as part of our plans for care pathways and services.

3.1. Support with making healthier choices and action on health inequalities

3.1.1 The wider determinants of health

The new PCNs are expected to help prevent ill health and tackle health inequalities through undertaking local needs analysis and proactive population health and prevention at the local level. By developing **population health management** approaches to better understand and predict needs before they arise, we will ensure that preventative actions reach the children, young people and adults who could benefit the most.

This applies whether interventions are delivered in the community, for example through the newly emerging PCNs and making links with civic and community partners, and the role of services such as housing and leisure, to impact the broader determinants of health, or through working with integrated community health and social care services and making sure services are accessible to all.

Public Health are working to compile **population health packs** to help PCNs and their local system partners to make informed decisions regarding their priorities for development and strategic direction. Poor health outcomes and need for services are strongly associated with deprivation, and we will use this opportunity to explore priorities for wider system partnership action across the wider determinants of health. This will include the further development of social prescribing pathways and community-based support in 2020/21 to support mental health and wellbeing.

As part of the next phase of prioritisation and delivery planning, we will also work with the SH&CP to use national guidance when it is published to set **trajectories for narrowing inequalities** in 2023/24 and 2028/29 to inform local wider system action planning.

3.1.2. Smoking, obesity and alcohol

The LTP also sets out some specific areas of action on smoking, obesity and alcohol as part of a stated aim for more action by the NHS on prevention and reducing health inequalities. This also reflects local priorities and we will continue to support this through our established partnerships that bring together a range of organisations to deliver programmes of work. As part of national enabling actions to support implementation at scale across the NHS, indicators and datasets will also be developed to monitor the impact of these prevention activities on health inequalities.

We have set out below how we will support prevention in these areas through existing partnerships and programmes. We have included the high level objectives, and more detail can be found in individual strategies and plans.

Smoking

Local action on smoking is taken forward through the work of the East Sussex Tobacco Control Partnership. The partnership is currently in the process of updating its strategy and there are also links to the Sussex-wide Local Maternity System objectives for saving babies' lives and prevention; the East Sussex Smoke-Free Pregnancy Partnership, and; the Illegal Tobacco Partnership. Our objectives are:

Wider Determinants	Primary Prevention	Secondary Prevention	Tertiary Prevention
• Reducing availability of tobacco	• Stopping people starting smoking	• Smoking Cessation Services – general population • Smoking cessation in pregnancy • Smoking cessation for pregnant women	• Smoking Cessation Services for high risk outpatients, and NHS inpatients (selected sites in 2020/21, with phased implementation for all from 2021/22)

Obesity

The East Sussex Healthy Weight Partnership takes forward local work on obesity, with links to the Sussex Local Maternity System (LMS) prevention workstream. Our objectives are:

Wider Determinants	Primary Prevention	Secondary Prevention	Tertiary Prevention
• Improving infrastructure to enable increased physical activity • Improving food environment	• Promoting physical activity • Promoting healthy eating	• Effective weight management services • Diabetes prevention programme (DPP), **(**targeted funding available for 20/21 and 21/22 for a small number of sites to test these ideas)	• Specialist weight management for BMI 30+ with T2DM or hypertension (potential targeted funding available for 2020/21 and 2021/22 for a small number of sites to test these ideas) • Enhanced Tier 3 services for people with more severe obesity and co-morbidities

Alcohol

Action on alcohol is overseen by the East Sussex Alcohol Partnership. The partnership is currently in the process of updating the East Sussex Alcohol Strategy. There are also links with the work of the Community Alcohol Partnership in Hastings. Our objectives are:

Wider determinants	Primary Prevention	Secondary Prevention	Tertiary Prevention
• Reducing availability of alcohol	• Supporting people to enjoy alcohol in moderation	• Supporting people to cut down and reducing alcohol-	• Effective detox services

		related harm to communities	• Alcohol Care Teams for hospitals with highest rates of alcohol dependent admissions (potential targeted funding available for 2020/21)

There may also be potential for national targeted funding to support action in the following areas, and we will explore opportunities if they arise:

Air pollution
Funding from the NHS Sustainable Development Unit to spread best practice in sustainable development, including improving air quality, plastics and carbon reduction to support action on air pollution, as well as action to reduce NHS production of pollutants (transport, buildings, purchasing etc).

Antimicrobial resistance
Support available to regions to drive progress in implementing the government's five-year national action plan to reduce overall antibiotic use and drug resistance.

3.1.3. Increasing screening and vaccinations programmes across East Sussex

We need to make a concerted effort to improve our rates of screening and immunisations to prevent avoidable diseases. This includes having a tailored approach to areas of greatest need by understanding the communities that suffer poorer access (such as through geography, deprivation or entrenched cultural values), and ensuring we have a greater focus on populations where there are lower rates of access and uptake. For example, trying new approaches to working with vaccine hesitant communities, and broadening the role of the wider workforce in opportunities for checking people's immunisation status and promoting the value of screening and immunisations.

3.2. Supporting self-care, self-management and personalised care

It has long been recognised that supporting people to be more in control of their health and social care, and building on their individual strengths and the assets within their circumstances, is key to successful prevention. The NHS LTP sets out the **NHS comprehensive model of personalised care** which has six main evidenced-based components:

- Shared decision making
- Enabling choice, including legal rights to choice
- Personalised care and support planning
- Social prescribing and community-based support (funding available through the Network DES Contract from 2019/20)
- Supported self-management
- Personal health budgets and integrated personal budgets

This model will be developed in full by PCNs by 2023/24 through the Network DES Contract national service specification for personalised care. Some services will be best delivered within a framework of wider local coordination and support. In 2020/21 we will make a start on this through building on our local evidence base for what works developed through our existing initiatives, pilots and pathways in the following ways:

- Ensuring that prevention, **self-care** and **self-management**, **shared decision-making**, **choice** and **personalised care and support planning** approaches are built in to identified

planned care pathway and **end of life care** developments in 2020/21, where appropriate, using NICE guidance and other available condition-specific tools.

- Reviewing our **patient activation measure** (PAM) pilot to inform further development of self-care and self-management. PAM is a way of assessing an individual's knowledge, skill, and confidence for managing their health and healthcare. Using it enables self-care and self-management approaches to be targeted appropriately. We have been testing the use of PAM in some healthcare settings since March 2018, and a review is expected in December 2019, which will inform next steps.

- Building on the rollout of **wheelchair personal health budgets** to identify further groups of people who could benefit from Personal Health Budgets and/or integrated personal budgets, for example for people with continuing healthcare needs.

During the next phase of prioritisation and delivery planning, we will work as a system to roll out personalisation more widely. This will include participating in work being undertaken on a Sussex-wide basis, to inform and define the expected trajectories for improvements over the next five years.

3.3. Social prescribing and community based support

In East Sussex, a partnership between the three CCGs, ESCC, the voluntary, community and social enterprise (VCSE) sector and other partners is taking forward developing and implementing an integrated **social prescribing** framework, in order to reduce inequalities in access and health outcomes for local and diverse populations, and improve **mental health and wellbeing.** Our approach aims to align **PCNs' social prescribing DES investment** with the benefits that have already been achieved, for example, through our existing commissioned social prescribing commitments such as the Community Connector Service.

The programme is being overseen by a multi-agency steering group with clinical input. The programme's 2019/20 key objectives include:

- Agreeing a consistent East Sussex social prescribing definition
- Establishing relationships and strengthening partnerships with PCNs
- Developing and agreeing outcome measures using NHSE's guidance
- Providing Continuing Professional Development (CPD) for linkworkers and other relevant multi-agency staff and volunteers
- Establishing consistent referral and support pathways
- Using Patient Activation Measures (PAM) to personalise support for people / patients

The newly commissioned **asset-based wellbeing** programme which will be delivered in partnership between the VCS and ESCC, will work with communities with poorer health outcomes in each of our districts and boroughs to identify what matters to them, and to build solutions from their strengths – including skills and knowledge, social networks and community organisations. These co-produced solutions will add to the range of support which social prescribers can signpost people to.

3.4. Preventing situations from getting worse

Building on our work to trial proactive care, in 2020/21 we will work collaboratively with PCNs to begin to implement **anticipatory care** as part of the PCN Network Contract requirements from 2020/21 onwards. This will introduce more proactive and intense care for patients assessed at being of high risk of unwarranted health outcomes, including patients receiving palliative care.

We will link this with the development of **multi-disciplinary care coordination** working with primary care teams, as part of our work to implement a target operating model for **community health and social care services**. More broadly, we will ensure that early intervention and

anticipatory, proactive care and reablement focussed aftercare is a key feature of the target operting model for community services. More information about our plans in this area can be found in Appendix 3.

Our longstanding **Home from Hospital** and **Take Home and Settle** services provided by voluntary organisations to support our community pathways for avoiding unnecessary unplanned admissions to hospital, and supporting successful discharge. Mobilisation of newly commissioned services will start in November 2019.

In the context of the unwarranted variation in falls programme across the Sussex Health and Care Partnership, our next steps for **falls prevention services** include exploring earlier intervention and targeting the services at those who are risk of falling, but are yet to fall, and looking at a primary care led fracture liaison service in the High Weald Lewes Havens area of the county.

Care for the Carers estimates that there are 66,269 **unpaid carers** in East Sussex looking after an ill, older or disabled family member, friend or partner. The role can have a big impact of a person's physical and mental wellbeing, as well as affecting them financially. Set out below are the estimated figures for each area, including approximately 3,000 young carers aged 5-17[9]:

- Wealden 18,549
- Lewes 13,027
- Rother 12,675
- Eastbourne 11,988
- Hastings 10,030

We will work with PCNs to help implement supporting carers in general practice a framework of quality markers (NHS England 2019) to help **better identify and support carers** of all ages, provide evidence for the Care Quality Commission and:

- Improve the health of carer and promote positive wellbeing
- Reduce carer crisis and family breakdown
- Reduce unwarranted variations in career support
- Meet demand more appropriately and better manage demand on services

Through our joint commissioning there are existing developments that currently support identification and support for carers:

- A Carers Social Prescription which is available in all GP practices in East Sussex, which can be populated from patient records and sent securely online, with Care For the Carers then making contact within two working days
- A Primary Care Support Service pilot which provides Community Support Workers with the overall aim of providing flexible and responsive short term interventions to patients with dementia and other long term conditions (including functional mental health and substance misuse), and their carers; and identifies carers not known to primary care/and/or not accessing support services
- A 'brief bite' carer awareness training offer is also available for busy practices

[9] Figures calculated by Care for the Carers based on projected growth from 2011 UK census figures

Based on the positive feedback received from GPs about these services, agreement has been secured to roll out the Primary Care Support Service on a county-wide basis. We will further build on these initiatives and explore ways to work with PCNs to ensure that identification and support for carers is fully integrated into the new **social prescribing** link worker arrangements described in paragraph 3.3. above.

3.5. Working together to improve health outcomes for vulnerable and/or disadvantaged groups in the population

Part of our work involves specific action where we know groups of people within our population are at risk of poor health outcomes. Current areas of focus include:

- Improving the healthcare needs of people with learning disabilities, through increasing **annual health checks** for people aged 14 years and over with a learning disability
- Our multi-agency **Rough Sleepers Initiative** which is integrating housing, health, mental health, substance misuse and social care and support to improve outcomes for rough sleepers. More information about this initiative can be found in Appendix 6.
- Recommissioning **housing-related support** services for people aged 16 years and over. In order to achieve integrated housing, health, employment and social care services and outcomes for people who are either homeless, or at risk of homelessness or living in housing that doesn't meet their needs or struggling to manage / maintain independence. New services will start in November 2020 as a result of partnership working between ESCC, district and borough councils, the VCS, NHS and the Department for Work and Pensions.
- In addition to the plans for **carers** set out in paragraph 3.4 above, we are implementing a new **outcomes-based commissioning model** for young and adult carers services. New services are due to start in November 2019, so that carers have the support they need to carry out their role in a sustainable way.
- Appendix 2 sets out a number of priorities to support vulnerable **children and young people** including promoting and protecting children, young people and families' needs in disadvantaged communities, action on County Lines and integrated working to improve outcomes of children with special educational needs and disability (SEND).

3.6. Mental health and wellbeing

The Five Year Forward View for Mental Health highlighted that more needs to be done on prevention to reduce inequalities, including a greater focus on preventing suicide. To support this Public Health England (PHE) have published the national Prevention Concordat for Better Mental Health for all (PHE, October 2019), to guide local areas in developing a coherent approach to better public mental health.

The concordat sets out ways to increase the focus needed on prevention and the services that impact on the wider determinants of mental health. This includes a shift towards prevention-focused leadership and action embedded throughout the mental health and wider system across the NHS, social care, education, employment, housing, community resilience and cohesion, safety and justice, and civil society. In turn, this will impact positively on the NHS and social care system by enabling early interventions and help.

The value of this approach has also been highlighted in:

- What Good Public Mental Health Looks Like. Public Health England & Association of Directors of Public Health (2019)
- Advancing our health: prevention in the 2020s Green Paper.
- Future in Mind. Promoting, protecting and improving our children and young people's mental health and wellbeing (DoH & NHSE 2015)
- Children and Young People's Transforming Mental Health Green Paper

- ‘Thriving at Work’ the Stevenson / Farmer review of mental health and employers (2017) highlights employers’ roles in promoting good mental health.
- Preventing suicide in England. A cross-government outcomes strategy to save lives (HMG 2012). The national suicide and self-harm prevention strategy for England sets out a blueprint for localities and signals the principle that ‘good prevention is also good suicide prevention’.

In East Sussex we recognise that promoting good mental health is key to preventing avoidable illness, improving outcomes for our population and reducing inequalities. We will work with all stakeholders across our system to explore and work towards ways of adopting the principles set out in the prevention concordat. This will enable a clear focus for our cross-sector action to deliver a tangible increase in the adoption of public mental health approaches.

A specific area of focus is children and young people’s (CYP) mental health under the work of the East Sussex CYP Mental Health Local Transformation Partnership. Our next steps will be informed by the outcomes of the Sussex-wide review of emotional support and wellbeing support for children and young people.

In summary our action in this area involves building on and strengthening our partnership working across the local NHS, social care, education, employment, housing, community resilience and cohesion, safety and justice, and civil society to further develop our approaches to public mental health. We will explore the potential to linking this with population health management approaches described in paragraph 3.1.1. to support targeted action in the following areas:

Wider Determinants	Primary Prevention	Secondary Prevention	Tertiary Prevention
• Providing children with the best start in life • Quality employment • Quality of housing and open spaces • Safe and connected communities	• Whole school approaches to promoting good mental health and emotional wellbeing • Workplace initiatives • Suicide prevention – social marketing and training for professionals • Reducing social isolation • Mental health promotion – Every Mind Matters • Improving smoking, diet and physical activity • Reducing substance misuse • Social Prescribing	• Working alongside our schools to provide appropriate help at the earliest point • Self-referral to Improved Access to Psychological Therapies (IAPT) • Crisis support via NHS 111 • Improving access to peri-natal services • Social prescribing • Integrated approaches to physical and mental health through our plans for care coordination and multi-disciplinary health and social care teams.	• Access to more specialist services if required but with step-down services in place • Crisis care

		• Supported accommodation pathways. • Crisis cafés • 24 hr crisis care • Therapeutic acute inpatient care • Back to work schemes	

Appendix 2
Children and Young People – programme summary

1. Background
The NHS Long Term Plan and local East Sussex priorities for children and young people require a strong partnership approach across our local NHS, East Sussex County Council, schools and the voluntary and community sector.

As part of the East Sussex Health and Social Care Plan, this appendix outlines out how we will continue to work closely as a system across NHS and Children's Services to support age-appropriate integrated care, including integrating physical and mental health services; joint working between primary, community and acute services; and supporting transition to adult services to improve outcomes for children and young people in East Sussex. Place-based integration of services and co-production with children, young people, families and carers will help us to:

- Support a strong start in life for our children and young people, including:
  - Promote and improve mental health and emotional wellbeing.
  - Work together to safeguard children.
  - Improve outcomes for children and young people with Special Education Needs and Disability (SEND).
- Support children and young people and families to live longer, healthier lives through helping them make healthier choices.

The following partnerships and boards have a key role in supporting the delivery of this work:

- The East Sussex Safeguarding Children Partnership which supports and enables all professionals working with children and families in East Sussex to work together to safeguard children and promote their welfare.

- The Children and Young People's Trust which works to improve outcomes for children and young people. In particular, it aims to support those who are vulnerable to poor outcomes.

- The East Sussex Children and Young People's Mental Health Local Transformation Plan Board which oversees the children and young people's mental health and wellbeing local transformation plan.

- The East Sussex Children and Families Strategic Planning Group which brings together senior decision makers/ officers across health, social care, education and public health in order to improve outcomes for children and families and support greater integration and or alignment of planning processes and service provision.

Our priorities for integrated working are informed by the current inspection regime which includes two local area, partnership inspections that look at how well we work as a system in the following areas:

- The Ofsted and Care Quality Commission (CQC) ***joint inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities***. East Sussex was inspected in December 2016 – East Sussex report
- The Ofsted, CQC, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and Her Majesty's Inspectorate of Probation ***Joint Targeted Area inspections*** which look at how effectively agencies are working together in their local area to help and protect children. Each set of joint inspections evaluates the multi-agency response to a particular issue or theme. Themes include safeguarding, mental health etc.

We are committed to ensuring that the voice of children and young people informs our work. Opportunities to get involved are at three levels:

- At the individual level, through direct involvement in personal care or support planning.
- Opportunities to help shape the design and development of services for children and young people.
- Informing strategic decision-making through mechanisms including the Youth Cabinet, Children in Care Council, Through Care Voice Group and in partnership with other youth voice groups through the Youth Voice Practitioners Network.

We will also work with our workforce across the system including schools, health, community health, social care, Primary Care Networks, nurseries and other childcare providers, and voluntary and community organisations to help deliver our shared objectives.

2. East Sussex priorities for transforming children and young people's services

We have looked at our priorities in the context of five key areas for integrated working:

- Children and young people's mental health and emotional wellbeing
- Disability pathways
- Safeguarding (including contextual safeguarding)
- Universal child health offer
- Looked after children

2.1. Children and young people's mental health and emotional wellbeing

Our objectives are:

- Improving our pathways and commissioning approach particularly with regard to tier 4/ secure/specialist placements.
- Developing a coherent emotional wellbeing strategy which works alongside our schools to provide appropriate help at the earliest point.

This priority will be delivered through our partnership work on the children and young people's mental health and wellbeing local transformation plan. There is also a Sussex-wide independent strategic review of children and young people's emotional health and wellbeing. The outcomes are due at the end of December, with a report due in January 2020, and the recommendations will be used to inform implementation planning in this area with a range of partners across our system.

Mental health services across the country have also been asked to increase access for children and young people as part of the five year forward view for mental health, and our work through the Local Transformation Plan sets this out in more detail.

Priority next steps to support this include:

- Pan-Sussex development of Care Education Treatment Reviews, led by CCGs, to prevent needs escalating and high cost hospital admissions.
- To support mental health and wellbeing consider a wider roll out of the general practice prescription pad initiative. Currently available in Hastings and Rother, this is a tool which enables GPs and other practice staff to refer parents, carers and young people to Open for Parents and / or I-Rock.
- Fully develop a dynamic risk register of children and young people at risk of hospital admissions with wrap around services in place

Work in this area has strong links with actions set out in Appendix 6.

2.2 Disability pathways

Our overall objective is to further develop our work around integrating the education, health, and social care needs of children and young people, aged 0 – 25, aimed at producing local solutions.

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. Our SEND Strategy 2018-2021 is designed to improve outcomes for pupils with SEND across East Sussex and has four shared strategic aims which were jointly identified by professionals from education, health and social care and parent/carers and community groups:

- Improving communication with families, children and young people.
- Building capacity for inclusion in settings, schools, colleges and services.
- Effective transition at every stage including advanced planning of the journey of the child.
- High quality provision, services, outcomes and aspirations.

Where do we need to get to?

We need to:

- Improve the long term outcomes for children and young people with disabilities through earlier planning of transition into adult services.
- Improve joint commissioning arrangements to secure high quality provision for children and young people.
- Establish clear lines of responsibility and accountability for supporting children across universal targeted and specialist services.
- Build capacity in our providers to improve early identification and reduce the number of children moving into high cost provision.

How will we get there?

- All partners make a clear commitment to delivering the outcomes in the SEND strategy, through working together.
- Work jointly with parents and carers of children and young people with SEND to improve confidence in local provision and jointly commissioned support services.
- Commit to joint funding of new specialist provision to support children with Profound and Multiple Learning Difficulty (PMLD).

Digital

- Develop systems for the effective sharing of information regarding the assessment of children with SEND.

Our priority next steps to support this include:

- Review the commissioning of health providers for assessing children and young people with autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) and other neurodevelopmental disorders, and explore a single assessment pathway.
- Review the current offer across education, health and care to children with PMLD and/or complex health needs alongside processes for the allocation of funding across different statutory agencies.
- Improve early planning for children who will transition into adult health and social care services, potentially starting in the areas of diabetes and neurodevelopmental disorders.
- Further develop the integration of social care personal budgets and personal health budgets for the highest need children with complex health needs.
- Review the commissioning of mental health support for children and young people with autism.

2.3. Safeguarding (including contextual safeguarding)

To improve our integrated approach to safeguarding and contextual safeguarding our objectives in this area are to:

- 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, and review of service offer and needs for 18-25 year olds.
- Make strong links with the work taking place under the mental health and wellbeing priority.

Where are we now

The number of children in need of help and protection is rising locally and nationally, potentially linked to the increase in families experiencing greater financial difficulties and an increasing awareness of the risks posed by exploitation/County Lines etc. One of our over-riding principles is to work, with partners, with the right children and families, in the right way, for the right amount of time to bring about change. We help to create a stable environment in which children can thrive and help families to develop resilience and coping strategies to avoid public service dependency. Individual and community responsibility is of fundamental importance in helping us manage demand over the coming years, supported by good public health services (particularly for young children).

The number of children (aged 0-17) will increase by 3% in the next three years. Our public health and targeted early help services help parents to care for their children in ways which effectively promote their development and well-being, so that they can make the most of their opportunities in early years education, school and college.

Where do we need to get to?

We need to:

- Use communities and individuals as resources e.g. via the volunteer programme in the 0-19 service, so that the health, wellbeing and development of children is a wider priority and not ‘just the business’ of statutory services.
- Further develop an integrated support offer that targets children and families early on and before problems become entrenched.
- Continue to develop confident and emotionally literate schools so that they can support children who are experiencing difficulties.
- Measure the effectiveness of our partnership response to children who are subject to criminal exploitation.

How will we get there?

- Look for quick wins and possible connections to highlight the needs of children and families in existing strategies such as in the Community Safety Plan, etc.
- Enhance existing training strategies so that we increase the capacity and confidence of a wider range of staff and partners in our communities.
- Look for all available external funding opportunities to increase resources for key priorities.
- Review existing systems and future service design.

Digital

- Develop an improved digital support offer and better signposting for children and their families.
- Explore the potential for the development of improved access for partners to contribute to assessment and safety planning for children.

Our priority next steps to support this include:

- Reviewing our current multi agency structures for young people presenting with high risk of serious violence/criminality and young people involved/at risk of criminal and or sexual exploitation.
- Delivering contextual safeguarding interventions where the need for Substance Misuse Service (SMS) expertise is identified by Multi Agency Child Exploitation (MACE) and multi-agency scoping meetings.
- Reviewing the current Public Health allocation for substance misuse (drugs and alcohol) and explore alternative allocations for prevention services.
- Reviewing Child Protection Information Sharing (CP-IS).
- Extending the health offer for children in secure accommodation at Lansdowne Secure Children's Home in line with the extension from a five to a 12-bedded unit.
- Considering the development of a consolidated approach to children suffering trauma e.g. Lansdowne, Youth Offending Team (YOT) and the NHS South East health and justice pathway.
- Extending support to care leavers who become parents and develop the role of corporate grandparents, in line with learning from serious case review.
- Continue to embed the new child death process which sits under the governance of local authorities and CCGs (formerly the responsibility of Local Safeguarding Children Boards)

2.4. Universal child health offer

Our work on integration to date provides a firm foundation for bringing together a coordinated range of preventative services that are critical to giving every child the best start in life, helping people to help themselves, and to stay healthy. Our objectives in this area are to further develop our integrated working to better enable:

- Provision of the Healthy Child Programme for under 5s through the integrated Health Visiting and Children's Centres service.
- Delivery of prevention interventions through the School Health Service.
- Nurseries, schools and hospitals to become health promoting settings.

Early identification is crucial to effective safeguarding. Effective delivery of the Healthy Child programmes, including universal development reviews for all children age 0-5, supports early identification of families with additional needs. This is delivered via an integrated service with health visitors for 0-5 year olds.

Where do we need to get to?

We need to:

- Give every child the best start in life and support people to maintain good health and promote healthy lifestyle choices.
- Strengthen integration across services.
- Work with needs identified at universal mandated reviews and providing enhanced support from a range of partners across services.
- Intervene early and proactively to prevent conditions and situations from getting worse.

Our priority next steps to support this include:

- Establishing a new 0-19 integrated service, structures, systems and evaluation data.
- Piloting evidence-based listening visits to support perinatal mental health.

This also has strong links to the action on reducing health inequalities set out in (Appendix 1).

2.5. Looked after Children

To improve our integrated approach to looked after children (LAC) and children previously looked after, our objectives in this area are to:

- Ensure looked after children's needs are prioritised across health, social care and education to enable best outcomes.
- Ensure mental health services are commissioned to optimise the emotional wellbeing of looked after children and previously looked after children.

Where are we now

The number of looked after children in East Sussex, as at 31 March 2019 is 600 a rate of 56.6 per 10,000. This is below the Income Deprivation Affecting Children Index (IDACI) rate of 60.7 (644 children).

Providing health assessments with statutory timescales is a challenge in East Sussex highlighted by increased reporting and assurance requirements from the CCG and the County Council.

Despite the fact that we have a designated service within the Child and Adolescent Mental Health Service (CAMHS) for LAC and within the Adopted Children CAMHS for previously looked after children, there are some challenges to accessing timely and appropriate emotional health support for these groups of children.

Where do we need to get to?

We need to:

- Further improve and sustain the health offer for looked after children by providing timely access to health reviews in line with statutory guidance with the aim to improve health outcomes.
- Improve assurance across all health services for looked after children to ensure services respond appropriately to their specific needs.
- Achieve enhanced access to emotional wellbeing services, with services commissioned adequately to meet looked after children's needs (including unaccompanied asylum seeking children)

How will we get there?

- Implementation of an enhanced Sussex wide service specification to meet statutory health requirements for looked after children
- Enhance the training strategy so that we increase the visibility of this group of children and the capacity and confidence of a wider range of staff and partners in our communities specifically around looked after children
- Sussex review of emotional wellbeing services will inform the commissioning for services to meet looked after children's needs

3. Summary of key priorities for 2020/21

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 support for transition to adult services we have agreed five 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 alongside 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, aged 0-25, aimed at producing local solutions, including:

- Integrated health and social care budgets for children with the highest complex needs
- Exploring a single assessment pathway for autism spectrum disorder and attention deficit hyperactivity disorder, and other neurodevelopmental disorders
- Improving early planning for children who transition into adult health and social care services
- Reviewing mental health support for children and young people with autism

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, and review the service offer and needs for 18-25year olds.
- Make strong links with the work taking place under the mental health and wellbeing priority.

Universal child health offer

- Provision of the Healthy Child Programme for under 5s through the integrated Health Visiting and Children's Centres service.
- Support the delivery of the preventative interventions through School Health Service.
- Support nurseries, schools and hospitals to become health promoting settings.

Looked after Children

- Ensure looked after children's needs are prioritised across health, social care and education to enable best outcomes.
- Ensure mental health services are commissioned to optimise the emotional wellbeing of looked after children and previously looked after children.

Appendix 3
Community – programme summary
1. Background
Our work and initiatives on integration to date has piloted and delivered a range of improvements in our journey to a new model of integrated care and the ongoing development of community health and social care services and initiatives, including:

- health and social care teams
- crisis response and proactive care
- the Dementia Support Service
- Health and Social Care Connect (now available 24/7365 days a year)
- the Joint Community Reablement Service.

We will continue to make progress with this and most critically the joint management of community health and social care teams. We want to further build on the services we provide in people's homes or in the community. We will achieve this through making sure that there are clear, simple pathways for people accessing services in the community and build on the support we provide to people after they leave hospital. We also have plans to further integrate teams of health and care staff across the county, supported by a single leadership structure.

The priorities and projects for the community programme are a mix of our ongoing work to support integrated working and new work to embed, further develop and grow our integrated community health and social care model and other local priorities. This is informed by:

- The NHS Long Term Plan
- East Sussex Urgent and Emergency Care workshop (August 2019)
- System diagnostic work and reviews carried out by NHSE and Improvement and others into on the drivers of our East Sussex system deficit in 2018/19
- NHS Rightcare
- Model Hospital
- The learning and early outcomes of pilot projects taken forward this year.

Our approach is consistent with the NHS LTP direction for primary and community healthcare. This includes the establishment of Primary Care Networks; greater multi-disciplinary working across primary medical care and community health and social care to both support rapid response in a crisis; as well as a local approach to proactively managing population health and anticipating and preventing the escalation of health and care needs.

Phase one of our programme in 2019/20 set out a series of pragmatic and realistic steps to be taken over the next six to twelve months. These will progress fuller integration of community health and social care services, with the overall aim of supporting people's independence and long-term care closer to home, so that our acute hospital services are better able to respond to the needs of local people. In brief the projects have included:

- In Eastbourne, nursing and social care teams have come together to trial working from a shared base, to support more and better **joint working** including **care co-ordination** for people with complex and longer-term support needs. This pilot is guiding how joint working best functions, and will include engagement with primary care, mental health and voluntary services.
- New **'Home First'** pathways have been tested out. These are new, joined up pathways designed to get medically fit people home from hospital sooner, and to make sure that assessments for community support and decisions about longer term care are not made in hospital.
- Joint working between East Sussex County Council and East Sussex Healthcare NHS Trust Occupational Therapy staff is being developed, to **share skills, best practice and**

help create capacity. As a minimum this is expected to include developing a joint duty and triage service that will simplify and streamline the referral and allocation process; however, the planning is already moving on to look at fully integrating the service across community health and social care

- Work has also been taking place to look at the best ways for different teams and services to work together to **provide integrated, rapid response, community services** to support discharge from hospital and avoid unnecessary hospital admissions. An integrated multi-disciplinary model has been developed and is being explored with staff. The model is designed to ensure that there are no barriers or gaps in the rapid response service; when needed it will have the remit, skills and capacity to respond. This builds upon the continuing development of the Crisis Response service (referenced elsewhere in this summary) which will continue to avoid unnecessary admissions and attendances by managing medical crises in the community where appropriate.

Taking these specific projects and pilots forward in the context of wider improvements to the quality and experience of care for our residents in 2019/20, has led to the following progress and benefits:

- Successful pilots of Home First approaches have evidenced that people left hospital more quickly and had better outcomes when discharged under these pathways. The pathways are delivered by joint working between social care staff in acute settings and community health and social care reablement staff in the community. With improved joint patient-finding in acute settings these pathways are now progressing to full implementation. A single access point ensures patients are settled at home, in community beds or in nursing care with the support they need. These pathways are now progressing to full implementation.
- This has been a factor contributing towards the average length of stay in hospital and community clinical care beds performing better than expected - reducing unnecessary length of time in hospital; accelerating recovery, and; releasing bed capacity within our hospitals and community sites to meet demand.

2. Key priorities for 2020/21

Our ongoing focus for the services we provide in people's homes or in the community is to build capacity, identify instances where more joint working would be of benefit and have clear pathways for people accessing services.

A high level integrated target operating model for community health and social care in East Sussex has been developed with ESHT, SCFT and ESCC working together to design the model. This work is in its early stages and the intention is to use the model as a vehicle for engaging more widely with key partners – primary care, mental health and the voluntary and community sector - and also to identify the priority projects that will deliver the model. The target operating model is designed to meet the key strategic priorities for health and social care services; and thus is a key element of our response to the Long Term Plan.

Within the 'blueprint' provided by the target operating model in 2020/21 we will build on our work on the phase 1 projects and pilots described above, with some pragmatic and realistic steps towards fuller integration of community health and social care services. with the overall aim of supporting people's independence and long-term care closer to home, so that our acute hospital services are better able to respond to the needs of local people.

This includes continuing to make progress with:

- Building on the co-location pilot in Eastbourne, we are identifying and exploring opportunities for co-locating nursing and social care teams to trial working from a shared base, to support **joint working** and the **care co-ordination model** for people with complex

and longer-term support needs. We are currently looking at accommodation options in Hastings and St Leonards.

- Linked to co-location, we are also progressing a pilot on **care coordination** of people with multiple long term conditions and support needs, to test the benefits and inform how this sits within our wider target operating model for community health and social care. A key part of this will be developing mechanisms for enhanced case level collaboration with primary care, mental health and voluntary sector support services.
- Continuing to progress the wider roll out of **Home First** pathways, to make sure that assessments for community support and decisions about longer term care are not made in hospital so medically fit people can get home from hospital or another community setting sooner.
- Joint working between East Sussex County Council and East Sussex Healthcare NHS Trust Occupational Therapy staff will be developed, to **share skills, best practice and help create capacity**. We are currently looking at whether/how we move to a fully integrated community therapy service across social care and community health.
- A key element identified in the target operating model and currently being worked up is to provide **integrated, rapid response, community services** to support discharge from hospital and avoid unnecessary hospital admissions.

To enable greater levels of **multi-disciplinary working across primary medical care and community health, mental health and social care services** our next steps will focus on developing and implementing our agreed **common target operating model** for 2020/21. A key challenge will be to deliver the same service framework across the East Sussex footprint with levels of service flexed due to local population needs. This high level operating model will consolidate the pilots and projects from phase 1 of our community programme into a single county-wide approach aimed at delivering the following:

- Maximising independence and maintaining people in the community – helping people to live independently at home for longer
- Preventing unnecessary hospital attendances and admissions
- Reducing length of stay in hospital by supporting timely and effective hospital discharges
- Enabling system design and planning to optimise the use of all available resources

The target operating model for integrated core community health and social care services will help build the **capacity, workforce and partnerships** to do this, and will develop in a phased way to ensure alignment and strong relationships with:

- PCN footprints to support effective **multi-disciplinary team working** including work to implement the PCN Network DES Contract for 2020/21 and risk stratification of local populations, to enable **proactive anticipatory care** for those with multiple long-term conditions and/or assessed at high risk of unwarranted health outcomes
- Pathways for the acute hospital (ESHT) **Integrated Discharge Team** interfacing with the community Home First pathways
- Developing further capacity in **crisis response** within two hours and **reablement care** within two days; noting the need to align the offer across the East Sussex footprint.
- The next steps in relation to the wider development and roll out of **Enhanced Care in Care Homes** to reduce acute hospital admissions by enabling better early identification and forward care planning
- **Structured medication reviews** for priority groups
- **Personalised care and support planning**
- **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

End of life care (EOLC)

Across East Sussex 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. Where appropriate, conversations take place about death and dying at an early stage, supporting people to make plans and communicate these with those who are important to them. This care extends beyond death to include bereavement and support for families.

In EHS and HR, partners are working together to deliver the aims and ambitions for End of Life Care identified within the End of Life Care Strategy (2019-2022). The Strategy was developed with the following partners - East Sussex Healthcare NHS Trust, East Sussex County Council, Eastbourne, Hailsham & Seaford CCG and Hastings & Rother CCG, St Wilfrid's Hospice, St Michael's Hospice Chestnut Tree Hospice, Demelza Children's Hospice, Adult Social Care, Care for the Carers, Age UK Sussex and patient and parent representatives. The aim is to deliver joined up care to support patients, their family, carers and those close to them to live independently as possible and achieve the best outcomes.

To ensure the delivery of the strategy an implementation plan has been drafted with nine key workstreams:

- Sharing of information to ensure care is co-ordinated across agencies
- Improving staff capability through learning and development to ensure the workforce has the knowledge, skills and attitudes to delivery high quality care
- Communications and patient and public engagement to include the views of patients, their family and carers to improve care
- Improving patient care through clinical effectiveness and governance to ensure care meets national standards and staff delivering care are competent, confident and capable
- End of Life care strategy and implementation plans to ensure the vision is clear and we meet our aims
- Care of the dying to ensure best end of life care for patients in community and that it is delivered with compassion and dignity
- Care after death by treating every patient with dignity and respect and equally supporting the bereaved
- Care of the dying child to ensure appropriate and timely transition to adult services
- Out of hours care to ensure services are fully integrated and accessible to enable patients to remain in the community if this is their wish

End of Life Care Vision 2017-19 outlines a strategic vision for end of life care and recommended next steps in the High Weald Lewes Havens area. This is evidence based and has been developed with local partners, with six key ambitions:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff are prepared to care
- Access to community support

Plans are being taken forward to support the two key priorities for End of Life Care:

- Support and training to Care and Nursing Homes, including communication
- Ensuring the EOLC vision for HWLH links with other priority areas including Frailty and the Enhanced Health in Care Homes (EHCH) service, and community services.

A project board is being established to identify the priorities for 2020/21 and beyond to ensure delivery of the strategy. This will include exploring an East Sussex-wide approach and the possibility of bringing together existing working groups, and building on the implementation work currently being progress across the county including:

- The case for change for anticipatory prescribing to meet NICE Quality Statement for anticipatory prescribing
- Timetable of education for primary care
- Linking with other priority areas for example, Frailty and the Enhanced Health in Care Homes (EHCH) service, and appropriate areas of community services
- Multi-agency workshop for verification and certification of death to inform Sussex wide guidance.
- Implementation of ReSPECT across acute, secondary and primary care providers and in hospices and care homes, including; communication and engagement with the general public and other stakeholders; GP training; and digitalisation of the ReSPECT form. ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.

Appendix 4
Urgent Care – Programme Summary

1. Background

The key aim of the Urgent Care (UC) programme is to transform urgent and emergency care services in East Sussex to ensure that, in an emergency (i.e. serious or life threating conditions) or in case of an urgent (i.e. non-emergency) need, people are treated and supported in the most appropriate place by the right clinical and/or social care service.

Through working in partnership with local Primary Care Networks (PCNs), acute, community, mental health and social care services, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and the East Sussex CCGs, the programme places emphasis on avoiding unnecessary hospital admissions through:

- Building pathways and capacity within community and primary care services by developing urgent care pathways to support patients in their own home or community settings.
- Building on the services already provided in our Accident & Emergency (A&E) departments, acute medicine and surgical assessment units to make sure that those presenting to an acute site seeking urgent care are seen by the most appropriate clinician, treated, and either admitted or discharged as soon as is appropriate.

There are strong links to the community programme which is described more fully in Appendix 3. The East Sussex urgent care programme is also closely aligned with the Sussex Health and Care Partnership (SH&CP) Sussex-wide Urgent and Emergency Care (UEC) Strategy and Integrated Urgent Care (IUC) programme, to deliver a consistent and standardised approach to urgent and emergency care pathways across Sussex. The projects are a mix of existing work to implement and embed a new model of 24/7 NHS 111 Clinical Assessment Service (CAS) and Urgent Treatment Centres (UTCs), and further developing and growing the urgent care model and other local priorities informed by:

- The NHS Long Term Plan (LTP) and LTP Implementation Framework
- The Keogh Review (2013)
- Sussex Health and Care Partnership (SH&CP) UEC plans
- Urgent and Emergency Care System Demand Diagnostic 2018/19 (ESHT)
- Qualitative Research with Patients in A&E at the Conquest Hospital in Hastings and Eastbourne District General Hospital (August 2019)
- East Sussex Urgent and Emergency Care workshop (August 2019)
- System diagnostic work and reviews carried out by NHS England/Improvement and others into the drivers of our East Sussex system deficit in 2018/19
- NHS Rightcare, Model Hospital and Get it Right First Time (GIRFT)

The programme is making progress with significant improvements for our residents through delivering the following benefits:

- **Extending Ambulatory Care** Rapid multi-disciplinary team working, discharge assessment and follow up has meant that 42% of the patients admitted to hospital via A&E are discharged less than 24 hours after admission, leading to zero length of stay. This is particularly significant for our frail patients who are known to deteriorate rapidly if admitted to hospital.

- From December 2018- October 2019, our **High Intensity User service** saw **55** patients. In the period to August 2019, **352** A&E attendances and a further **98** non-elective admissions were avoided (accounting for 36 patients).
- **The Frail and Vulnerable Patient Scheme** This locally-commissioned GP service is focussed on moderately and severely frail patients with a Rockwood score[10] of 5-7, as well as palliative care patients. The scheme includes assessment, personalised care planning and reviews, medication reviews and a falls assessment. 6,462 care plans were produced in 2018/19 and these are being peer reviewed annually.
- **Urgent Treatment Centres** will be up and running in line with the national mandate by December 2019, providing consistent access to an urgent care service to diagnose and deal with many of the most common ailments for which people often go to A&E. This service will build on the success of our **GP Streaming Service,** which was successfully launched in October 2018 and enabled GPs and primary care practitioners to work more closely with A&E staff.
- **Primary Care Improved Access (PCIA)** – since October 2018 **PCIA** has delivered additional capacity within primary care for same-day primary care needs, and expanded patient choice by offering appointments after 6.30pm during weekdays and in the mornings on weekends and bank holidays
- **NHS 111 Clinical Assessment Service (CAS)** will become fully operational from 1st April 2020, and will offer local people a single point of access for urgent and emergency care services, including the ability to book appointments at UTCs or other walk in services, and also within primary care.
- **GP-led respiratory care** has reduced the number of hospital admissions for Chronic Obstructive Pulmonary Disease (COPD)
- Our approach to **end of life care** pathways has also been aligned to our Urgent Care model, more detail is set out about this in Appendix 3.

2. Key priorities for 2020/21

Our focus in 2020/21 includes continuing to implement, further develop and embed the following projects and initiatives:

2.1 Extending acute frailty

This looks to build in the appropriate interventions when people require hospital care to ensure they receive a timely frailty assessment, and supports patients to return home or to another appropriate care setting, when patients no longer require consultant-led care in an acute setting. Subsequent community services will also be aligned on discharge to reduce frailty severity where possible. The current focus is:

- Expansion of **acute frailty teams and pathways** to ensure right support at the hospital 'front-door'
- Supporting **Same Day Emergency Care (SDEC)**

[10] The Rockwood Score is a clinical frailty scale to assess needs and plan interventions

2.2 Extending Ambulatory Emergency Care (AEC)

AEC is a way of managing a significant proportion of emergency patients on the same day without admission to a hospital bed, giving the opportunity to better manage patient flow, improve patient experience and reduce acute hospital admissions. AEC is already provided by our hospitals; however, this project looks to increase the availability of AEC to a minimum of 12 hours a day, 7 days a week. This will also help meet requirements in the NHS LTP to increase treatment and discharge from emergency care without an overnight stay. This is currently live in Eastbourne DGH and will be expanded to the Conquest Hospital to support **SDEC.**

2.3 Expanding our high intensity user service

To address the increased demand on our A&E services, in November 2018 a **high intensity user (HIU) service** went live in East Sussex. The HIU service (initially developed by NHS Blackpool) offers a robust way of reducing high unscheduled users of multiple services such as 999, NHS 111, A&E, General Practice and hospital admissions. This in turn frees front line resources to focus on more clients and reduce costs. It uses a health coaching approach, engaging with high users of services whose needs are often unable to be met fully by one area of service.

The service supports some of the most vulnerable clients within the community to flourish, whilst making the best use of available resources. The service is now fully operational with two key workers visiting high users of services with very significant improved outcomes evidenced already. Our next stage is to expand the scope and reach of the service to ensure patients who are frequent users of other services, (for example mental health, ambulance and primary care) are also identified and offered appropriate support (not always medical or clinical). The aim is to make sure these patients are enabled and empowered to manage times of crisis by utilising the most appropriate urgent or emergency care service.

2.4 Expanding Community Frailty/PEACE planning (advance care planning)

The Proactive Elderly Advance Care (PEACE) planning process and documentation helps health and care professionals to deliver the best care to frail, older people, based on a personalised approach to care and support planning. Combined with a Comprehensive Geriatric Assessment, PEACE Planning has been shown to reduce admissions by up to 83% and bed days by up to 94%[11]. It also offers improved outcomes for patients, families and carers (including health care and care home staff) through increased independence, confident decision-making, and by supporting patients to receive care and to die in their preferred place.

The Community Frailty Service currently completes around 230 PEACE plans per year. We anticipate rolling out PEACE planning to a greater number of patients as part of personalised care and support planning roll-out and supporting patients in care homes.

2.5 Integrated Urgent Care Model

Continuing to roll out and embed:

- **Urgent Treatment Centres (UTCs)** are GP-led services that are equipped to diagnose and deal with many less serious injuries and urgent ailments people often attend A&E for. Open at least 12 hours a day, every day, UTCs offer appointments that can be booked through NHS 111 or through a GP referral. This is an existing project as part of

[11] Audit of Frailty Service patients, April 2016-April 2019, activity 12 months before and after discharge

the national requirements to implement UTCs and develop a standardised approach to make best use of emergency care resources across Sussex. UTCs are intended to ease the pressure on hospitals, leaving other parts of the system free to treat the most serious cases. This includes reducing attendance at A&E and, in co-located services, provides the opportunity for streaming at the front door. These will be rolled out in Eastbourne DGH and the Conquest Hospital in Hastings by December 2019. There is currently a minor injuries unit (MIU) at Lewes Victoria Hospital and a plan has been agreed recently for a brief closure of this service, with interim arrangements in place to allow improvement works in readiness for the UTC to open in the Spring.

- We will also be developing the Minor Injuries Units in Crowborough and Uckfield to provide support for patients with minor ailments as well as injuries, through a mix of nursing and medical staffing these will provide opportunities to mitigate increasing demand on Emergency Departments and improve local access for same day care.

- As part of implementing UTCs we are reviewing our **walk-in centres** to ensure the right balance of services and to maximise the role of out of hospital services that complement the new UTC facilities.

- **Clinical Assessment Service** to support patients to navigate the optimal service 'channel' we will embed a single multi-disciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services from April 2019 including:
  - Direct booking into **Primary Care Improved Access**
  - Direct booking into Primary Care Extended Access, UTCs or other walk in services and sites being developed as part of the East Sussex integrated urgent care model

- Increased utilisation of **Primary Care Improved Access** capacity – working with Primary Care Networks as a system to review location and access to those services

2.6 The **Locally Commissioned Service (LCS) for chronic respiratory conditions** provided by General Practice has been implemented, aimed at supporting the better management of respiratory conditions in the community to ensure people are less likely to deteriorate, and reducing emergency admissions. This project looks to measure the outcomes from providing training workshops, regular out of hospital reviews of medication, and medication application techniques.

3. Implementing the NHS Long Term Plan and new local priorities

In addition we are building on progress made with the above projects and initiatives to scope and implement the following priorities as part of our comprehensive model of urgent care:

3.1 Our **Ambulance Conveyances** project provides the ability for our ambulance staff, paramedics and GPs to contact our Crisis Response team via Health and Social Care Connect (HSCC) to avoid an unnecessary A&E admission, for common conditions that result in 999 calls and an unscheduled conveyance to A&E. It will include new clinical pathways that can be managed outside of hospital.

3.2 Reforms to hospital emergency care – **Same Day Emergency Care (SDEC).** New diagnostic and treatment practices allow patients to spend just hours in hospital rather than being admitted to a ward. This also helps relieve pressure elsewhere in the hospital and frees up beds for patients who need quick admission either for emergency care, or for a planned operation. Through moving to a comprehensive model of SDEC we will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third.

3.3 Enhanced care in care homes is aimed at developing and testing a range of initiatives that offer dedicated support to care homes, such as dedicated primary care ward rounds. This programme will build confidence for staff and avoid unnecessary admissions. It is currently at the exploration stage of looking to understand how appropriate support can be delivered to people in care home settings in partnership with Primary Care Networks. An enabler for all enhanced health in care homes projects is the alignment of care homes to specific practices. This process of alignment is underway.

3.4 The **NHS Clinical Standards Review** is due to be published in the Spring 2020. We will develop new ways to look after patients with the most serious illnesses or injuries, ensuring that they receive the best possible care in the shortest possible timeframe. In addition, the East Sussex 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 actions and interventions to take forward in winter 2019/20 and 2020/21.

4. Key milestones for urgent and emergency care

- In 2019 England will be covered by a 24/7 Integrated Urgent Care Service, accessible via NHS 111 or online.
- All hospitals with a major A&E department will:
    - Provide SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20.
    - Provide an acute frailty service for at least 70 hours a week. The service will work towards achieving clinical frailty assessment within 30 minutes of arrival.
    - Aim to record 100% of patient activity in A&E, UTCs and SDEC on the same system by March 2020.
    - Test and begin implementing the new emergency urgent care standards arising from the Clinical Standards Review, by November 2019.
    - Further reduce Delayed Transfers of Care in partnership with local authorities.
    - By 2023 the Clinical Assessment Service will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.

5. Summary of urgent care priorities for 2020/21

Working with partners across primary care, community, mental health, social care and ambulance services, 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 SH&CP plans for Urgent and Emergency Care and include a mix of work to implement Urgent Treatment Centres (UTCs) and local priorities:

High intensity users

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

Ambulatory Emergency Care (AEC)

- Expansion of AEC at both EDGH and the 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

- Work with Primary Care Networks to develop and testing a range of initiatives that offer dedicated support to care homes, to better support patients in care homes, build confidence for staff and avoid unnecessary hospital admissions.

Community frailty/PEACE planning

- Further rollout of Proactive Elderly Advance Care planning as part of personalised care and support planning roll-out; supporting the cohort of patients in care homes.

Integrated Urgent Care

- Rollout of enhanced NHS 111 and Clinical Assessment Service from 1 April 2020.
- Rollout of UTCs at Eastbourne DGH, Conquest Hospital, Hastings and Lewes Victoria Hospital
- Direct booking into Primary Care Improved Access, UTCs or other walk in services and sites being developed as part of the East Sussex integrated urgent care model.
- Increased utilisation of Primary Care 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.

Appendix 5
Planned Care – programme summary

1. Background
Our overall aim is to make sure that those people who are referred into hospital are seen and tested as quickly as possible. There will be quicker routes to tests, enhanced technology to detect any concerns faster and one stop clinics that will bring together consultations, tests, treatment and support in one place, at one time.

Planned care can be defined as routine services with planned appointments or interventions in hospitals, community settings and GP practices. This is also sometimes known as elective care and is any treatment that doesn't happen as an emergency and usually involves a prearranged appointment. Most patients are referred for planned care by their GP.

We want to make sure that those people who are referred into hospital are seen and treated as quickly as possible. There will be quicker routes to tests, enhanced technology to detect any concerns faster and one stop clinics that will bring together consultations, tests, treatment and support in one place, at one time.

The East Sussex planned care programme aims to optimise the use of resources across planned care pathways by reducing variation, and using evidenced based, clinically effective commissioning. This will ensure the best patient outcomes and experience and improve the productivity of acute and out of hospital planned care capacity. Our current focus is supporting more effective patient pathways between primary and acute care and working with the Sussex Outpatients Transformation Board to transform and digitally enable outpatients care.

Our local plans are informed by and developed in the context of the following:

- The NHS Long Term Plan
- NHS Rightcare
- Getting It Right First Time (GIRFT)
- Model Hospital
- Elective Care High Impact Interventions
- Guidance from the National Institute of Clinical Effectiveness (NICE) and the Royal Colleges
- Sussex Health and Care Partnership (SH&CP) Sussex-wide plans

Significant progress has been made with improving efficiency and productivity of planned care services across our system. This includes:

1.1 GP referral variation – our work with Primary Care to look at referral variation has led to a reduction in first outpatient appointments with no subsequent procedure or follow up. We are further developing this work through the establishment of a GP-led clinical reference group, under the banner 'Right Referral, Right Route'. This group is peer reviewing referrals on a practice and specialty level, with professional development and learning being disseminated across primary care. The group is also fostering closer working relationships between primary and secondary care.

1.2 Ophthalmology – we have used a High Impact Intervention methodology to map ophthalmology demand and capacity locally. We have responded to these findings by:

- Undertaking intensive waiting list validation
- conducting virtual review by consultants
- introducing failsafe procedures and changes aimed at optimising clinics.

This has generated efficiencies in the system, for example through a reduction in patients waiting for follow up. Further work continues in 2019/20 on a clinical strategy for Ophthalmology.

1.3 Clinically effective commissioning - East Sussex successfully applied the clinically effective commissioning policies where procedures with limited evidence of benefit where initial conservative therapy is effective and where a threshold for intervention may be appropriate or where NHS provision may be inappropriate

1.4 Musculoskeletal services – In line with the Royal College of Radiologist guidance that does not support the use of MRI or CT scans when dealing with MSK presentations, we have worked with our local providers to review the diagnostics undertaken for MSK related conditions. Following this, processes were put in place to manage diagnostic requests and reject those that were not clinically appropriate. The one exception concerns suspicions of cancer, at which point the patient would be referred under the two-week wait rule. As a result, reductions in both MRI and CT scans have been realised.

1.5 Diabetes pathway redesign - this is a project implemented last year and has resulted in successfully avoiding amputations and improving preventative care, by providing GP led multidisciplinary community teams as well as greater levels of patient involvement in decision-making and self-care. East Sussex CCGs are now leading on Diabetes pathway re-design across the SH&CP, to further build on this model and inform a Sussex-wide approach.

1.6 Medicines optimisation – the East Sussex CCGs Medicines Management team works in partnership with pharmacy teams in local NHS Trust providers and other providers to deliver a highly effective structured programme designed to integrated Medicines Optimisation (MO) services to improve medicines use across care pathways.

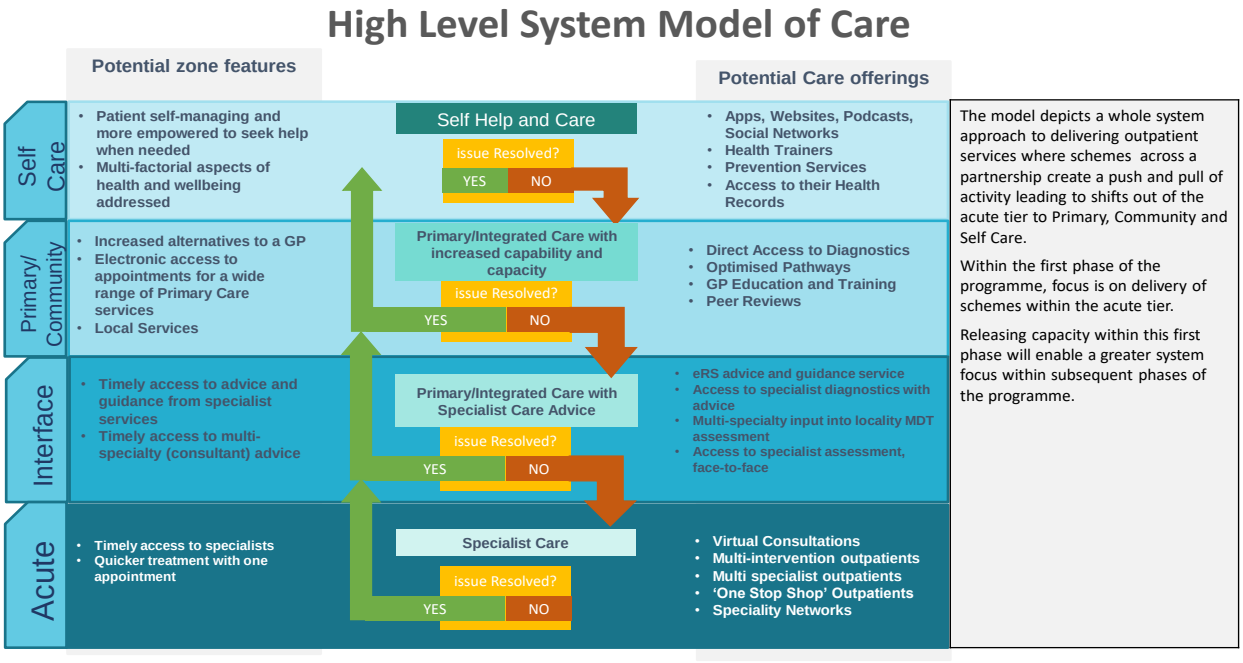
2. Key priorities for planned care in East Sussex

An outline of our key priorities for planned care in East Sussex is summarised below. All of our transformation priority areas will be underpinned by full pathway reviews. We will also ensure we reduce unwarranted variation and inefficiency in care pathways generally, by ensuring elimination of outdated concepts, introduction of one-stop diagnosis and reductions in unnecessary follow-ups wherever possible.

2.1 Outpatients

The vision for outpatient services developed by the system's stakeholders is:

"The East Sussex community will have timely access to specialist advice, care and treatment. This will be delivered through modern, efficient, and effective services that provide greater choice and less disruption to the daily lives of our community."



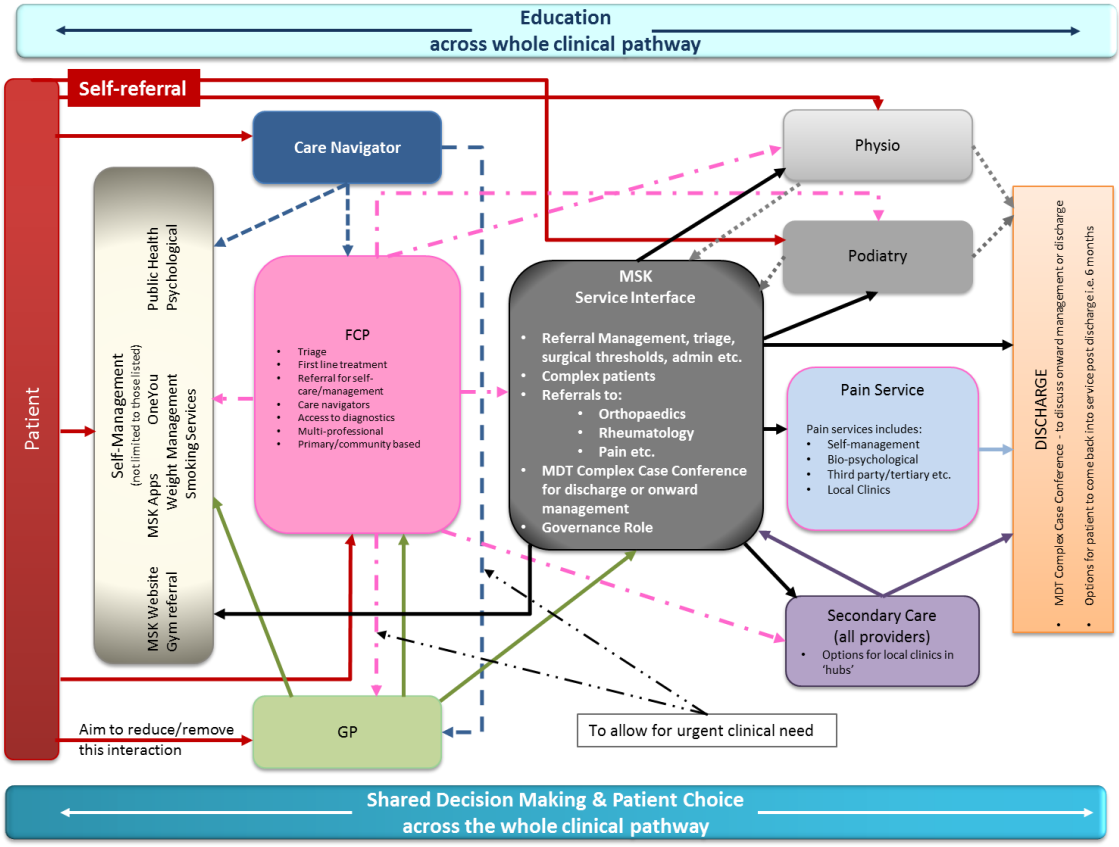
Outpatient appointments will be provided via the optimum channel i.e. video, telephone or face-to-face to ensure patients and clinicians are making best use of their time. East Sussex will have concluded and embedded optimal outpatient referrals by the end of 2019 enabling us to build on this to improve the efficiencies of the pathways.

2.1. Musculoskeletal (MSK) services in our area

In Eastbourne Hailsham and Seaford MSK Services are provided by Sussex MSK Partnership East, which offers a fully integrated service. The MSK triage (iMSK) service in Hastings and Rother is provided by East Sussex healthcare NHS Trust (ESHT). Our aim is to provide equity of service across East Sussex whilst aligning to the vision of NHS LTP and the transformation of MSK services - services delivered by the right person, in the right place, first time.

We are undertaking a review of MSK services, linked to our East Sussex MSK model, focussing on the reduction of unwarranted clinical variation of MSK services and re-design of the MSK community workforce to improve productivity. This includes first contact practitioners to provide faster diagnosis and treatment for people with MSK conditions. Pain management provision is also included in our redesign, including efficient use of community services. This programme is closely aligned with the SH&CP programme for MSK. The introduction of virtual fracture clinics will also form part of this programme.

Our agreed model of care is:



2.2. Evidence based interventions and clinically effective commissioning (CEC)

Part of a Sussex-wide programme, clinically effective commissioning (CEC) aims to review and standardise non-emergency treatments and procedures to reduce variation, reduce waste and make best use of limited resources. It supports referrers to use the appropriate guidelines agreed by clinical commissioners to ensure:

- unnecessary high-risk interventions are not carried out
- treatment is clinically effective

- management of referrals for procedures that are either not routinely funded, or require patients to meet certain eligibility criteria before they can receive treatment

This year more procedures will be reviewed with these principles in mind and work has commenced to implement the pathway redesigns.

2.3. Cardiology

Locally our population has high incidences of atrial fibrillation (AF) and heart failure (HF). These high incidences are driven by our older population and levels of deprivation described elsewhere in our Plan, which is why our work on health, wellbeing and prevention is so important. This is also a significant driver of elective and non-elective cardiology spend in secondary care. With AF cases, and stroke-related hospital admissions predicted to rise as the population ages, this could put significant pressure on primary and secondary care services.

Our work on cardiology is therefore focused on ensuring our local East Sussex services are designed to cope with these current and future challenges. We are aiming for a reduction in the use of isolated coronary angiography, an increase in identifying and supporting patients to self-manage their own heart health through using the patient activation measure tool, and a reduction in variation in spend/activity across our CCG areas. These aims will be delivered through application of NICE guidance to all interventions, equitable community cardiology services across East Sussex and reduction in unwarranted variation.

There are a range of projects focused on cardiology. These include looking to reduce variation in the way community cardiology provides community-based assessments for people who may have problems with their heart, blood pressure or breathing, and standardising the use of procedures such as Computerised Tomography (CT) scans and angiograms. This project is looking to standardise pathways across the east and west of the area and so more patients can be treated within the community setting to make best use of capacity. In acute cardiology, we are reviewing the acute model of care to support the long term clinical sustainability of the service.

2.4. Diabetes

The prevalence of type 2 diabetes across our area is 6.9% and is in line with the average for England. However, local data within our CCGs shows variation in care and outcomes – and our programme of work described in the next section looks to address this. Overall, we are aiming for:

- improved patient experience for people with diabetes
- reduction in outpatient appointments
- reduction in non-elective admissions
- reduction in amputations
- improved access for psychological therapies for people living with diabetes with co-morbid depression/anxiety and;
- improved workforce retention within our local services.
- improved access to innovative technologies for glucose monitoring for patients with type 1 diabetes (includes flash and continuous glucose monitoring).

Building on the success of service redesign now being rolled out across the Sussex system, we acknowledge predicted exponential growth in Diabetes, and will plan how we will manage this as a system over the next 3 years.

2.5. Ophthalmology

In response to an all-party parliamentary group on eye health capacity, NHS England has initiated a high impact intervention scheme, requiring Trusts and CCGs to work together to look at their demand and capacity in this area and come up with a plan to ensure the system is ready to respond. Across our CCGs, data is being reviewed from all acute trusts and community providers of ophthalmology services. The aim is to agree a solution to the predicted growth in the number of patients at risk of losing their sight. The role of **community ophthalmology** is central to this, with the longer term aim of expanding the remit of community providers to monitor stable patients and triage new conditions.

In East Sussex our work on this priority area that supports our patients to have a positive experience of care in the right place, first time. It aims to keep them well for longer, reducing or eliminating the risk of losing sight, with all the additional challenges that sight loss brings to the wider system and the economy. We know it requires our acute and community providers to work closely together to ensure a seamless pathway. We are working to ensure that our local system can respond to current and future demand in eye health for our patients.

We will implement a planned NHS-managed choice process for all patients who reach a 26-week wait, starting in areas with the longest waits and rolling out best practice through a combination of locally agreed targeted initiatives and nationally-driven pilots. This is currently being managed from a Sussex-wide position and local implementation plans will be developed in time for implementation by end of March 2020.

Over the coming months we will be working with Brighton and Sussex University Hospitals NHS Trust (BSUH), East Sussex Healthcare NHS Trust (ESHT) and Sussex Community NHS Foundation Trust (SCFT) and our other providers to ensure the 26-week-wait policy is fully implemented for April 2020. Where there are known issues we are currently seeking to commission further capacity from the local independent sector providers, and we are also exploring opportunities for patients across a wider regional geography, particularly where there is spare capacity and short waiting times. Leads from the East Sussex CCGs and ESHT have already been identified, and as part of the Sussex-wide work we will also work closely with Surrey Heartlands as a Fast Mover pilot site looking to share learning.

2.6. Cancer

Cancer is a national and local priority, as reflected by the National Cancer Strategy Achieving Word Class Outcomes for Cancer 2015-2020: A Strategy for England: Report of the Independent Cancer Taskforce Review[12] as well as the cancer plan for the Sussex Health and Care Strategy, which was signed off in April 2019. In the context of the Cancer Alliance and Sussex-wide cancer plan, our aim is to continue to improve operational performance to support early diagnosis and treatment and to support our population to manage their own health and wellbeing through personalised care.

The priority areas for cancer include: prevention, early diagnosis, patient experience, living with and beyond cancer (personalised care) and modernising cancer services. Through the work of the East Sussex Planned Care Oversight Board, and the clinical leadership of the East Sussex Cancer Action Group, we will build on existing work during 2020/21 to take forward local plans in the following areas:

- Continue to improve performance against the cancer constitutional waiting times standards and ensure sustainability, including the new 28 day faster diagnosis standard.
- Work with PCNs to improve the uptake of screening targeting those areas with lower uptake and focussing on health 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.
- Strengthening the two-week wait process to ensure referrals are managed proactively to improve the Referral to Treatment RTT) waiting times.

[12] Achieving Word Class Outcomes for Cancer 2015-2020 A Strategy for England; Report of the Independent Cancer Taskforce Review (2015) : http://www.cancerresearchuk.org/sites/default/files/achieving_world-%20class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

- Ensure personalised care pathways in breast are implemented and plans for other specialties are developed, with prostate and colorectal as priorities for 2020/21.

3. Sussex Health and Care Partnership (SH&CP) programmes

East Sussex is fully engaged with the programmes of work managed by the SH&CP with local representatives on all the workstreams. Some workstreams are in early stages; head and neck, dermatology, cardiology, and some more further developed, for example MSK and fractures and falls.

Head and neck

To develop a model of care using national evidence and best practice that will ensure the long term sustainability of head and neck services, address the challenges faced by current providers in delivering head and neck services for our population; and ensure improved outcomes for patients.

Dermatology

To develop a model of care using national evidence and best practice that will ensure the long term sustainability of the dermatology services, addresses the challenges faced by current providers in delivering dermatology services for our population; and ensure improved outcomes for patients.

Cardiology

To develop a model of care using national evidence and best practice that will ensure the long term sustainability of the cardiology services, addresses the challenges faced by current providers in delivering cardiology services for our population; and ensure improved outcomes for patients.

Fractures and falls

To develop a model of care that is based on prevention and improved outcomes following a fall or fracture. There were two initial falls oversight groups earlier this year where four priority areas were identified. These priority areas have developed into four task and finish groups covering:

- Low level falls prevention & osteoporosis identification
- Non injured falls at home
- Post A&E attendance/hospital admissions falls prevention
- Fracture liaison service development

Musculoskeletal Services (MSK)

The model under development looks at how we can improve the patient experience from the first point of contact, so that they see a clinician with specialised MSK skills at the earliest possible opportunity. This in turn will streamline the rest of the pathway, when a referral to secondary care is necessary.

The role of First Contact Practitioners (FCPs) is becoming central to this, and we are feeding into the evaluation of FCP pilots with insights from our own pilots locally, to inform these discussions. This will help us understand the best way to make use of FCPs. Extensive patient engagement is being undertaken at an STP wide level, with patient forums being approached locally, and clinicians, commissioners and service managers have been attending the STP wide workshops to design the model.

4. Planned Care Priorities for 2020/21

Our aim for 20/21 is to make sure that those people who are referred into hospital are seen and tested as quickly as possible. There will be quicker routes to tests, enhanced technology to detect any concerns faster and one stop clinics that will bring together consultations, tests, treatment and support in one place, at one time. We will do this by prioritising on the following areas:

- Outpatients
- Musculoskeletal services
- Evidence-based interventions

- Cardiology
- Diabetes
- Ophthalmology
- 26 week wait capacity alerts
- Cancer
- Medicines optimisation

4.1. Outpatients

During the last 2 years we have made significant improvements in the referral pathways for patients from GPs to hospitals consultants by working closely together to ensure the flow of communication is the most effective for our patient care. Next year we will build on this success by:

- Introducing video appointments, virtual fracture clinics, electronic correspondence for our patients
- Expanding of successful approaches to:
    - improve the timeliness of treatment
    - improve the experience of patients on care pathways
    - reduce unnecessary appointments
    - introduce one-stop clinics specifically focusing on gastroenterology and breast cancer two-week wait.

4.2. Musculoskeletal services

During the last two years we have introduced community-based specialist teams to care for patients with musculoskeletal conditions, ensuring interventions are appropriate to individual needs and pain is effectively managed. Next year we will focus on the sustainability of services to meet the growth in demand by:

- Introducing First Contact Practitioners (FCPs) in GP surgeries designing the correct bespoke pathway to ensure timely recovery, minimised pain and improved independence
- Improving shared decision-making between specialist clinicians and patients with more complex conditions, alongside improved education on self-management.
- Enabling patients to self-refer to physiotherapy so they start treatment earlier at the onset of a condition
-

4.3. Evidence based interventions

More is now known about what types of treatment improve outcomes for our patients and during the last year we have been ensuring patients do not undergo unnecessary invasive procedures. We will continue to review the latest evidence and change our recommended treatments where this evidence indicates areas that do not benefit our patients, allowing us to release capacity for the right treatments.

4.4. Cardiology

Locally, we see a high incidence of heart conditions, driven by our older population and levels of deprivation. Our specialist heart clinicians are working together to agree a new model of cardiology care spanning general practice through to community services and hospital care. We are aiming for a model that:

- Increases identification of heart conditions and related support for patients to self-manage their own heart health
- Reduces variation in community-based cardiology assessments by standardising pathways, enabling more patients to be treated within a community setting to make best use of capacity

- Supports the long term sustainability of hospital services

4.5. Diabetes

Building on our success in implementing complex diabetes treatment in a community setting, and our expansion of urgent treatment for diabetics, we will continue to refine these services to:

- Provide improved patient experience for people with diabetes by reducing unnecessary hospital appointments including outpatient appointments and hospital admissions
- Provide improved access for psychological therapies for people living with diabetes that also have co-morbid depression/anxiety
- Provide improved access to innovative technologies for glucose monitoring for patients with type 1 diabetes (includes flash and continuous glucose monitoring).

We recognise the predicted exponential growth in diabetes and we will develop a plan to manage this as a system over the next 3 years.

4.6. Ophthalmology

Our work on this priority area supports our patients have a positive experience of care in the right place, first time. It aims to keep them well for longer, reducing or eliminating the risk of losing sight, with all the additional challenges that sight loss brings to the wider system and the economy. We know it requires our acute and community providers to work closely together to ensure a seamless pathway. Our focus next year is to address the growing demand by repatriating care to our specialist community optometrists, releasing capacity in our hospital multidisciplinary teams to manage the more complex eye conditions.

4.7 26-week wait/capacity alerts

We know some of our patients are waiting too long for treatment. We will implement a planned choice process for all patients who reach a 26-week wait, starting in areas with the longest waits. This will give patients options to access care across NHS services in Sussex

4.8. Cancer

The priority areas for cancer include: prevention, early diagnosis, patient experience, living with and beyond cancer (personalised care) and modernising cancer services. We will build on existing work. During 2020/21 we will build on existing work to take forward local plans in the following areas:

- Continue to improve performance against the cancer constitutional waiting times standards and ensure sustainability, including the new 28 day faster diagnosis standard
- Improve the uptake of screening targeting those areas with lower uptake and focus on inequalities
- Strengthen the two-week wait process to ensure referrals are managed proactively
- Implement personalised care pathways for breast cancer and develop plans for other specialties, with prostate and colorectal as priorities

4.9 Medicines Optimisation

Through a structured programme of work, the East Sussex CCGs medicines management teams work in partnership with pharmacy teams in NHS Trust providers and other providers to deliver integrated Medicines Optimisation (MO) services aimed at improving medicines use across care pathways. Although the outcomes we are seeking are broadly similar across our population and are being delivered in the context of alignment with Sussex-wide plans, approaches are flexed and tailored to local geographies in the county and relationships with different NHS Trust providers. Building on recent successes, some of the key priorities for 2020-21 include:

- Improving **value for money** through specific projects aimed at optimising prescribing in a range of areas including diabetes, pain management, malnutrition and anticoagulation; as

well as de-prescribing medicines no longer needed through NHS England led programmes such as low priority prescribing.

- Development of an Integrated Medicines Optimisation service and approaches between local GP primary care networks (PCNs) and local NHS Trust providers. This service will support the delivery of structured medication reviews and quality improvement in areas such as **antimicrobial stewardship** and **dependence forming medicines**.

- Continuation of successful **medicines optimisation in care homes** service to reduce inappropriate polypharmacy and working towards integration with the PCN structured **medicines review and optimisation service**, under the PCN Network Directed Enhanced Services (DES) contract in 2020/21.

- Focus on **medication safety** including rolling out the electronic transfer of medicines discharge information between hospital and community pharmacists; and implementation of a quality improvement process for pharmacy led interventions to enhance medication safety in General Practice.

- **Integrated vocational training programmes** for pharmacists and pharmacy technicians across primary and secondary care, mental health and community services.

5. Enabling delivery of planned care

In order to deliver the plans detailed above there are a number of key enablers that will ensure success.

Digital

Digital enablers such as Patient Knows Best and virtual fracture clinics are two areas looking to reduce waste on pathways and reduce patient travelling requirements to improve patient experience and outcomes. The initial focus will be on ophthalmology, gynaecology, and urology.

Workforce redesign

Robust workforce planning is a key enabler of the planned care efficiency and transformation programmes. Robust processes are in place with high quality data integrity and increased breadth and depth of insight to underpin short-term, medium term and long-term strategic planning. Cohesive workforce strategies are in place that balance quality and safety with financial sustainability through the identification of workforce optimisation principles that will support the future work programmes.

Appendix 6
Mental Health – programme summary
1. Background

The NHS LTP requirements for delivering a "new service model for the 21st century" by 2024, include the following ambitions:

- Better care for major health conditions: improving mental health services
- Meeting the mental health investment standard for adults, and children and young people's mental health services (new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24)
- Delivering the Five Year Forward View for Mental Health and NHS LTP commitments
- NHS-led provider collaboratives for specialised mental health, learning disability and autism services
- Stabilisation and expansion of core community teams of adults and older adults with severe mental health illnesses
- Testing and rolling out adult community access standards once agreed; services for people with specific and complex needs including people with a diagnosis of 'personality disorder'; Early Intervention in Psychosis (EIP); adult eating disorders and mental health community rehabilitation; and developing services for 18-25 year olds
- Fair share transformation funding from 2021/22 to 2023/24 to deliver the above services in new models of care integrated with primary care networks

Our work on mental health takes place in the context of the Sussex Health and Care Partnership (SH&CP) mental health programme priorities, and local implementation to support closer system working between physical and mental health, community health and social care, and primary care.

The overall vision for the SH&CP mental health programme is that by 2025, all people with mental health problems in Sussex will have access to high quality, evidence-based care and treatment. This will be delivered by integrated statutory, local authority and third sector services that are accessible, well connected with the wider community, and which intervene as early as possible to prevent mental ill health.

The SH&CP mental health programme priorities have been developed as a result of extensive public engagement with service users, carers, partner agencies, providers and commissioners. This has evolved through the Sussex Partnership NHS Foundation Trust (SPFT) Clinical Strategy (March 2017) and the STP Mental Health Case for Change (November 2017). The latest version of the SH&CP mental health programme takes account of NHS Long Term Plan commitments, with workstreams that seek to address the following priorities:

- Perinatal Mental Health
- Children and Young People's (CYP) Mental Health – including CYP Crisis
- Adult Common Mental Illnesses – Improving Access to Psychological Therapies (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

The SH&CP programme for mental health also has ambitions to further develop and strengthen the role of housing and third sector partners. A task and finish group (Sector Connector) has been

developed to support this diverse sector to influence change, and engage more fully in the work of our mental health programme. Proposals are being developed to:

- Enhance representation from housing and the third sector on the programme board
- Develop an East Sussex mental health forum (alongside mental health forums across Sussex)
- Develop an overarching mental health partnership board across Sussex.

Robust estates plans will also be key to the successful transformation of community, patient flow and rehabilitation workstreams including the development of more supported housing for local people. The LTP commitments expect an increase of over 600 staff over a 5 year period, so 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. There are also some stretching targets for remodeling community support and providing crisis support in the Sussex-wide plans, and this will require new facilities, with crisis cafés being embedded and located within local communities.

The plans for mental health are set out in full in the SH&CP Strategy Delivery Plan and response to the NHS LTP.

2. Transformation funding

In addition, **transformation funding** has recently been awarded to the Sussex Health and Care Partnership and this will enable SH&CP to build on the work we are already doing to improve patient and family experience of mental health services.

Specific areas of development include:

- **Children and young people**
  The East Sussex CCGs and East Sussex County Council (ESCC) have been awarded funding to set up three Mental Health Support Teams (MHSTs) covering approximately 24,000 pupils / 60 schools in total, focussing on groups of schools in areas with highest levels of need. These teams will provide specialist support to children and young people, through one-to-one and group psychological support, and working with families. This will build on the whole-school work on mental health and emotional wellbeing that is already underway, as well as provide additional support for children and young people with emerging problems, aligning with support pathways for individual children.

  Schools, pupils and parents will be involved in the design of the teams and the project is being delivered through an MHST implementation group with members from East Sussex CCGs and Child and Adolescent Mental Health Services (CAMHS) alongside a range of ESCC services working in schools, and Public Health.

- **Crisis resolution / home treatment**
  More specialist roles will be introduced to our existing 24/7 crisis resolution/home treatment teams to provide psychological interventions to prevent people from relapsing and having to be admitted to hospital.

- **Expansion of psychiatric liaison teams**
  A bid has been submitted to expand existing psychiatric liaison provision at Eastbourne District General Hospital (EDGH) and the Conquest Hospital in Hastings to enable the criteria for 24/7 provision of specialist mental health support set by NHS England to be fully met. This is already provided at the Royal Sussex Hospital in Brighton, and a similar bid is being explored for the Princess Royal Hospital in Haywards Heath.

- **Crisis cafés**
  Four new crisis cafés will be set up across Sussex, and will be open for 46 hours a week including evenings and weekends. The cafés offer an alternative to A&E for people who need specialist mental health support and use the expertise of our third sector partners. They are also accessible for people with learning disabilities and autism. There is already a

crisis café in Hastings, The Sanctuary, and the options are being explored for another crisis café elsewhere in the county.

- **Ambulance triage**

  The ambulance triage service involves qualified psychiatric nurses attending incidents where a person does not need medical or paramedical attention, but appears to be experiencing some form of mental health crisis. Within East Sussex we are currently reviewing existing ambulance triage services with a view to rolling out more widely.

- **Street triage**

  We will extend the successful street triage scheme to operate for 84 hours a week right across Sussex. We were one of the first systems in the country to develop this joint scheme between the police and mental health services, which involves a police officer and qualified psychiatric nurse attending incidents where a person is experiencing some form of mental health crisis. A review will take place with Sussex Police during the remainder of 2019/20, to see if the model needs to be refreshed.

3. Key priorities for 2020/21 in East Sussex

Initial workshops and discussions have taken place locally to further define the scope and nature of the work to build on existing Sussex-wide mental health plans and understand the specific developments for East Sussex. This has helped identify specific areas that will support closer system working across physical and mental health, community health and social care, and primary care. Information on our priorities to support better mental health and wellbeing for all can be found in Appendix 1.

The following areas are being taken forward in East Sussex and will be built on further in 2020/21:

- **Single point of access - no 'wrong doors' and access to crisis pathways**
  In order to enable people to easily access services, wherever they present, we are seeking to invest in the expansion of NHS 111 so that it can take mental health referrals. A pilot Single Point of Access (SPOA) for adults is also being developed for Eastbourne, embedded within Health and Social Care Connect (HSCC). In addition, pathways have been simplified and a joint operational policy is being co-produced to support joint working across mental health and social care teams.

- **Supporting people in the community through community health and social care teams for adults with severe mental health issues**
  Work is being taken forward by ESCC Adult Social Care and SPFT across a number of operational areas to enhance integrated working through community health and social care teams for people with severe mental health problems. This includes resource and quality practice panel processes, protocol development in relation to Approved Mental Health Professional (AMHP) duties, and access to Crisis Resolution and Home Treatment (CHRT) teams to help avoid unnecessary admissions. In addition, joint management meetings are being reviewed to ensure representation is appropriate for collaborating to solve problems.

  To enable better outcomes for people with serious mental illnesses through the wider integration of mental health teams and multi-disciplinary working, we are considering how to deliver a more integrated and multi-disciplinary approach to meeting physical health and mental health needs as part of the target operating model for community health and social are services.

- **Supported accommodation pathways**

  A review of supported accommodation pathways is taking place. This will identify people using mental health services that need specific housing support, to inform work with housing teams to find long term solutions.

  Supported accommodation is currently commissioned by Adult Social Care to provide medium-term (average of 18 months) accommodation-based support for:

  - Adults who are homeless
  - Adults who have mental health needs and are homeless
  - Young people who are 16-25 years old and homeless
  - Young parents and homeless

  There are currently 89 beds across mental health and homelessness, and 160 beds across young parents and young people, for a total of 249 beds. This provision will be recommissioned from December 2020.

  This offers an opportunity to re-consider how services are commissioned and delivered to meet the joint working requirements of Adult Social Care and its partners, including Children's Services, local housing authorities, registered social landlords, and the wider local population, including:

  - A sufficient supply of accommodation-based support to enable clients with Care Act/Children's Act/Homelessness Reduction Act-eligible needs and those at greater risk of eligible needs to live independently as quickly and sustainably as possible
  - An effective system of planning, allocating, managing and retaining oversight of accommodation
  - An opportunity to strengthen supported accommodation provision to support a wider range of needs, including more complex and challenging behaviour, in more appropriate settings, for example, smaller units of self-contained accommodation for people with higher levels of need, and step down flats within larger accommodation support-units to prepare for fully independent living
  - How supported accommodation can best be provided for a range of clients groups that struggle to maintain independent living and require support

- **Rough sleeping**

  The first round of funding through the rough sleeping initiative (RSI) has been crucial in establishing a multi-disciplinary approach to tackling rough sleeping. We have formed a multi-disciplinary team of health, mental health, social care and substance misuse professionals who are responsible for carrying out holistic assessments of each individual's needs. The team are led by the Rough Sleeping Initiative Project Co-Ordinator who has worked alongside each of the services to develop a new pathway for rough sleepers. The team has an outreach focus, which ensures direct access to statutory services for rough sleepers, who would otherwise be unable to access this support via traditional routes. The work of the team is supported by enhanced outreach and day centre provision in both Eastbourne and Hastings.

  In October 2019, 23 people were rough sleeping in Eastbourne and 30 people in Hastings. Since the project started, the RSI has supported 213 individual rough sleepers.

  A second initiative, 'rough sleeper's initiative 2' operates across Lewes, Wealden and Bexhill. This is a team of two navigators who work to offer outreach services to entrenched rough sleepers. The project launched in July 2019 to improve access to housing and support services for entrenched rough sleepers living in rural East Sussex.

The funding for these initiatives is currently available from the Ministry of Housing, Communities and Local Government until March 2020, and we will be pursuing opportunities to bid for funding for a further year.

- **Aftercare and support**
  To ensure people get the best support and aftercare, a new delayed transfers of care network has been established, with joint leadership from Sussex Partnership Foundation NHS Trust and ESCC Adult Social Care Services and weekly discharge meetings to support safe and timely discharge. A live section 117 register has also been implemented to better coordinate care across teams.

- **Access to children and young people's mental health services**
  An independent strategic review of the whole pathway of emotional wellbeing and mental health services for young people is taking place across Sussex. This has involved engagement with staff, partners and those who use services across the pathway. The outcomes are due at the end of December 2019, and this will inform implementation planning with a range of partners across our system.
  Services across the country have also been asked to increase access for children and young people as part of the five year forward view for mental health, and our work through the East Sussex Children and Young People Mental Health and Wellbeing Local Transformation Plan sets this out in more detail. There is also some more detail in Appendix 2.

Appendix 7

Summary of key themes from the audit of recent engagement activity in East Sussex

Theme	Which reports?
Joining up health and care services, partnership working and collaboration • 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 also 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 Our Health & Care Our Future (OH&COF) engagement people fed back that the creation of multi-disciplinary 'Health Hubs' was a great opportunity.	• Healthwatch • OH&COF[13] • SH&C[14] Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation • Listening To You • Takeover Day 2018: Mental Health and Emotional Wellbeing
Communication, access to information, and information sharing • 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.	• Healthwatch • OH&COF • SH&C Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation • Listening To You • Takeover Day 2018: Mental Health and Emotional Wellbeing
Digital • 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.	• OH&COF • SH&C Spring '18 • SH&C Autumn '18
Staffing, resources and funding • People acknowledged increased demand for care and appreciate honest conversations, but also emphasised the importance of having more/enough staff, that resources must	• Healthwatch • OH&COF • SH&C Spring '18

[13] Our Health and Care Our Future

[14] Shaping Health and Care

Theme	Which reports?
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.	• Big Health and Care Conversation • Listeing To You
The role of the voluntary and community sector, and social prescribing • 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 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.	• Healthwatch • OH&COF • SH&C Autumn '18 • Big health and Care Conversation
Health inequalities • 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.	• Healthwatch • OH&COF • Big Health and Care Conversation
Prevention and supporting healthier choices • 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.	• Healthwatch • OH&COF • SH&C Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation
Mental health • Issues discussed around mental health services include access, waiting times, support to meet people's needs, communication with people about their care. • People also raised communication with people about their care and support for those with autism and dementia during these sessions • Issues discussed around young people's mental health services included access to services and experience.	• Healthwatch • OH&COF • Big Health and Care Conversation • Takeover Day 2018: Mental Health and Emotional Wellbeing
Holistic and personalised care • 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.	• Healthwatch • OH&COF • Big Health and Care Conversation
Access to services and experience of services • There was lots of feedback from people about difficulty accessing services or not feeling they are getting enough support. For example, lack of co-ordination in the system,	• Healthwatch • OH&COF • SH&C Spring '18

Theme	Which reports?
availability and timeliness of appointments, availability of GPs/ health care professionals 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.	• Big Health and Care Conversation • Listening To You
End of life care • People highlighted the importance of better conversations and support around end of life care, including conversations with their GP.	• Healthwatch • OH&COF • Big Health and Care Conversation
Multiple and complex needs • People with multiple or complex needs find it more difficult to access the support that they need.	• Healthwatch • OH&COF