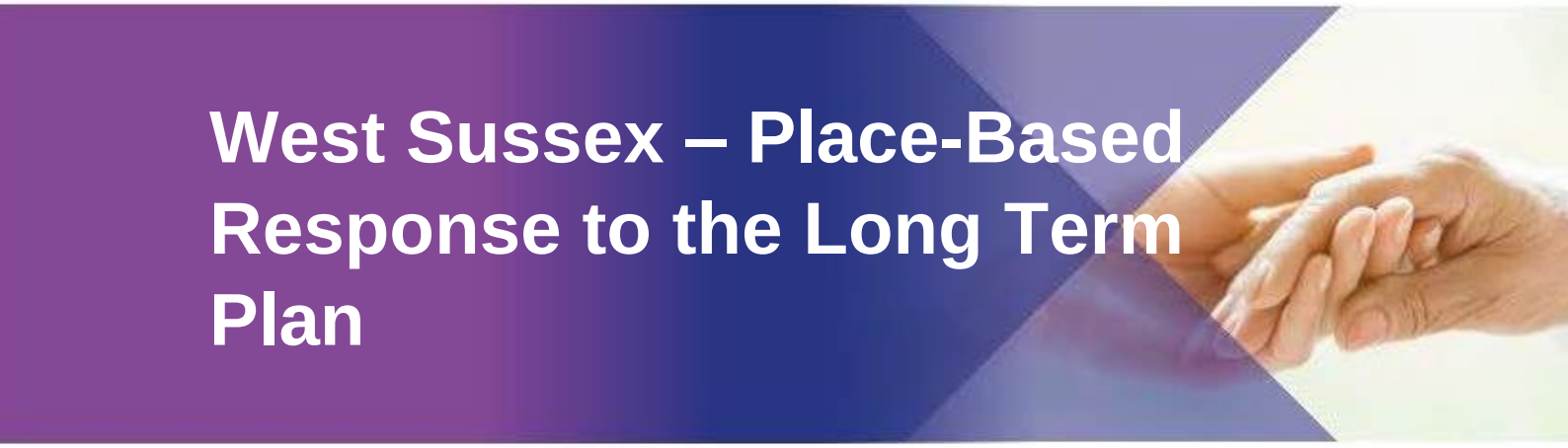
Sussex
Health and Care Partnership

West Sussex – Place-Based Response to the Long Term Plan



Working together for better health and social care

28th October 2019

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1. Introduction

West Sussex is a large and diverse county, covering over 750 square miles and home to over 855,000 people. It remains one of the least deprived areas in the country. In relation to the Index of Deprivation (2015), the county ranks 131st of 152 upper tier authorities (1 being the most deprived and 152 being the least deprived). The county mostly has a relatively high life expectancy, low unemployment, low child poverty rates and an outstanding natural environment and rich cultural assets.

Towns in West Sussex are frequently featured in national surveys and rated as top places people choose to live, retire or work. We rank in the top quartile of Local Authorities (LAs) on a range of measures known to have an impact on longer term health and wellbeing including the rate of employment for 16-65 year olds and first time entrants to the youth justice system. Teenage pregnancy has more than halved over the last 10 years, from 31.3 per 1,000 15-17 year olds in 2005 to 12.2 per 1,000 in 2016 and deaths (under 75 years) from cardiovascular disease (including heart disease and stroke) have fallen dramatically over the last 10 years from 88.6 per 100,000 in 2004- 2006 to 60.7 in 2015-2017. Overall, older people in the county are relatively healthy and the county is a great place to live. More people are continuing in paid employment well past the "traditional" retirement age, and older people provide considerable caring support to their families and friends, and the wider community.

However, this masks the health inequalities within the county. Some areas in Arun rank amongst the 10% poorest neighbourhoods in England. We know that the environment in which people are born, grow, live, work and age has a profound effect on the quality of their health and wellbeing. Many of the strongest predictors of health and wellbeing, such as social, economic and environmental factors, fall outside the healthcare setting. These wider determinants of health have a significant impact on people's health and wellbeing. The poorest and most deprived are more likely to be in poor health, have lower life expectancy and likely to have a long term health condition (LTC) or disability.

In West Sussex, NHS and LA partners have agreed to co-produce a joint response to the NHS Long Term Plan (NHS LTP) within the framework of the Sussex Health and Care Partnership (SHACP). The response is being developed following an extensive period of public and stakeholder engagement and will provide the basis for a delivery plan to achieve the joint Health and Wellbeing Vision for the county, as well as delivering a local response to clinical priorities and the objectives set out in the NHS LTP.

This process provides the NHS with an opportunity to work closely with local government and other partners to build on existing local efforts; and strengthen and implement preventative interventions that will close the local health and wellbeing gap, such as:

- Supporting a good start in life, including delivering a whole systems approach to healthy weight and promoting emotional wellbeing and good mental health in children
- Improving the health and wellbeing of working people through the development of workplace health and wellbeing programmes
- Preventing the development of LTCs through primary prevention programmes focused on the major causes of ill health, including smoking, poor diet, lack of physical activity, alcohol, mental health and loneliness
- Improving health outcomes for people with LTCs, including cancer through a staged approach of early detection, support for self-care and robust clinical management of

LTCs by addressing the physical health of those with mental illness to reduce the life expectancy gap

- Empowering citizens to remain independent in their own homes, taking an asset-based approach to support carers, strengthen social networks, communities and places - with the aim of making the healthier choice the easier choice and default choice
- Providing prevention advice and support to other clinical networks in Sussex footprint, such as the Cancer Alliance, Local Maternity System (LMS) and other clinical work streams and programmes of work, for example, screening and immunisations

Integrated working across health and care provides the opportunity to deliver the best possible outcomes for local people and achieve the best use of collective public funding in West Sussex. There is a strong national and international evidence base that demonstrates the value of integrated working in improving experience and outcomes, alongside delivering better value for money.

By developing a joint West Sussex health and care plan and having a clear place-based focus in our NHS LTP submission, we will ensure that the priorities for service transformation and integration required to deliver a new service model for the 21st century are grounded in the needs of our local population.

2. The Challenge facing West Sussex – The Case for Change

2.1 Population Need

Longer life expectancy has been a considerable public health success story. People are living longer but spend around 20% of their lives in poor health, often with multiple complex conditions. This presents challenges and pressures.

The population has increased by 9% over the last 10 years. This is in line with increases seen at a national and regional level, with the largest increase, of over 22%, in the 65+ age group. The population is, therefore, growing, and growing older. The county has a population of 192,500 over the age of 65. This is 22% of our population and compares with 19% in the South East and 18% in England. This pace of change is set to increase. For the past 15 years we have had, on average, 2,500 more people aged 65 years old each year. The population in West Sussex is projected to increase by a further 8%+ from 2016 to 2026 with larger increases projected in the older age groups (20%+) in the same 10-year period.

As the population ages, more people will be living longer with a LTC or disability and many people will be living with multiple LTCs. Almost two thirds of those aged 65-84 in West Sussex are estimated to live with two or more LTCs. This rises to four in five of those aged 85+. Many LTCs are strongly associated with age, but lifestyle risk factors are also important. A significant proportion of these LTCs are preventable. Loneliness and social isolation are also very real problems for our ageing population. More than 72,500 people above the age of 65 are living alone. A survey in 2013 found that 1 in 4 of older people reported being moderately or severely lonely.

Overall life expectancy is high compared with England, 80.6 years for men in (2015-2017), and 84.1 years for women, both 1 year higher than across England. Whilst life expectancy has increased, considerable inequalities persist. There are, for example, considerable differences in life expectancy between the most deprived residents and least deprived, 7.6 years difference for men, and 6.0 years difference for women (2015-2017). Life expectancy for those with a mental health problem or a learning disability is also significantly worse.

Alongside this trend, there is a gradual deterioration in outcomes for local people, a widening of health and wellbeing gaps and the potential impact of austerity on the local economic climate. Healthy life expectancy, for example, appears to be plateauing for men and has been falling for women. Female healthy life expectancy was lower than male healthy life expectancy in 2015-2017 (63.6 years compared with 65.8 years), suggesting a failure for our existing models of care in terms of responding to the changing demographic.

People have very different expectations than they had in the past. They want more choice and are often experts in their own care. People expect clear information about what treatment involves, the evidence that it works, the outcomes it will achieve and what happens next. They are less concerned about organisations, systems and pathways and they expect to be able to access information and communicate with the NHS using digital technology. Feedback from the public is that services are not joined up and that a lack of coordination across the system contributes to a poor experience of care.

2.2 Resource, workforce and capacity

The gap between available resources and projected spending requirements is expected to rise unless we act, and evidence suggests that adoption of new ways of working is not fast enough or effective enough to moderate the impact of demand growth. Analysis undertaken highlights evidence that there could be more management at the front end of pathways; that there is considerable and unwarranted variation between GP practices in terms of the use of secondary services; that we have fallen behind in areas such as keeping vulnerable people in stable employment and accommodation; and, importantly, that we have not invested in securing the benefits available from prevention.

Staff shortages in many parts of West Sussex combined with high turnover are also placing services under severe pressure. We face serious recruitment challenges. Nurses, GPs, occupational therapists, social workers and care support staff are all difficult to recruit. High turnover, particularly in the first year of employment, is costly and disruptive to services. Reducing reliance on a temporary workforce is a key driver for all providers. The challenge for employers is to create an environment and a culture that makes people feel valued.

There is also a capacity gap in general practice which is not resolvable by recruitment alone, and a new approach is needed. Projected demand for primary care is greater than practices' capacity to deliver, and faced with a recruitment crisis, there is a growing risk of service failure in general practice that could severely impact on all health and care services.

3. Our Vision for Health and Wellbeing for West Sussex

3.1 Our Health and Wellbeing Strategy for West Sussex

Our Vision

"West Sussex is a great place in which to grow up, achieve, raise a family and grow old, in strong, safe and sustainable communities – it is a place where improved health and wellbeing is experienced by all our residents, and the health and wellbeing gap between communities is reducing."

In 2019, NHS and LA partners from across West Sussex set out a strategy for the health and wellbeing of people in the county. *"Start Well, Live Well, Age Well: West Sussex Joint Health and Wellbeing Strategy 2019 – 2024"* is a tool to enable partners to set out a plan for action which will inform the planning, commissioning and provision of care and support. It aims to be concise and purposeful rather than a comprehensive review of work across the health and social care system. The Strategy provides a framework for the planning, commissioning and provision of services by NHS Trusts, Clinical Commissioning Groups (CCGs), LAs and voluntary sector organisations in West Sussex. It is not a stand-alone document, but sets the direction of travel, bringing together the many strategies and plans we already have under one clear vision and purpose.

The purpose of the strategy is to:

- Provide a context, vision and overall focus for improving the health and wellbeing of local people and reduce health inequalities at every stage of people's lives.
- Identify shared priorities and outcomes for improving health and wellbeing and reducing inequalities based on our Joint Strategic Needs Assessment (JSNA).
- Support effective partnership working that delivers health improvements for all.
- Set out a way to support and drive the innovation required to enable change.
- Support partners to embed these priorities within their own organisations and reflect these in their commissioning and delivery plans.

3.2 Planning together for West Sussex

Strong relationships between local government, the NHS, and communities are critical to the implementation of our strategy and a population health approach which puts the individual at the centre of the design and delivery of care and support. In Sussex we will have 3 "places" where NHS and LA planning are aligned. These will be co-terminus with upper tier LA boundaries for Brighton and Hove, East Sussex and West Sussex. Each place will be supported by 1 or more Integrated Care Partnerships (ICPs) responsible for delivering improved outcomes for our population.

We will use our response to the NHS LTP as a catalyst for developing West Sussex as a "place". We will focus on an approach which prioritises prevention, delivers person centred care, and tackles health inequalities. To ensure implementation, a delivery plan will be developed. The plan will be an integrated health and social care plan, focussing on the people who live, work and visit the county; across physical and mental health, and health and social care services for children and adults; from improving health and prevention through to primary and secondary care. The emphasis will be on setting out the

transformation priorities we need to deliver jointly to meet the future health and care needs of our population.

The process for developing the plan will be led by the Chief Operating Officer for Sussex CCGs, the Executive Director, Children, Adults, Families, Health and Education for West Sussex County Council (WSCC) and Chief Operating Officers from our provider organisations. They will engage with key partners to establish the right governance framework to deliver an initial plan by April 2020 and a detailed joint delivery plan covering how we will address our priority areas by September 2020. The initial plan will aim to:

- Refresh our place-based strategic plans to reflect the widest opportunities for joint working across the wider determinants of health
- Set out an initial view of the service improvements which we are realistically aiming to achieve over the next 4 years
- Establish key principles for system architecture in West Sussex including the development and delivery of ICPs; integrated commissioning; and designing a population health approach
- Describe a framework for programme governance
- Set out the finance, activity, digital, workforce and estates implications of our plans
- Describe how we will work with our communities and our staff to ensure better outcomes.

3.3 Partnership working

There is a shared recognition that our governance requires refreshing with a commitment required to a clear scheme of delegation and active participation in developing local partnerships. Figure 1 sets out our framework for partnership working. An interim partnership executive group, formed from provider and commissioner organisations, will be established to develop the infrastructure required to support governance, assurance, performance and financial management across the partnership map. The group will also prioritise activities to support improved partnership working over the period to April 2020 as follows:

- A joint plan for the development of an outcomes approach with clarity about;
    - how the measures will be developed
    - how services will change for people, communities and populations to reflect an outcomes approach
    - how outcomes will become a routine part of individual care planning, supporting people to assess themselves and to take more control of their care
- A programme of work using disaggregated data from current JSNA to identify inequalities in outcomes between different social groups and to support the prioritisation of interventions within specific communities across West Sussex
- Agreed plans to deliver an integrated care record and the development of a common data set and methodology to stratify risk covering health, social care and housing needs
- A shared approach, at place, towards the development of ICPs
- A framework for impact analysis which sets out the quantified impacts expected across the system including those on “downstream” hospital utilisation and the outcomes for populations.

Figure 1: Our framework for partnership working in West Sussex

A fundamental enabler to deliver our vision is the development of ICPs where NHS and LA providers work together to deliver outcomes and ambitions for the population. An ICP will work collaboratively with commissioners and communities to co-design new models of care and set the strategic direction and outcomes for the population. It is a partnership of health and care providers, including LAs, acute hospital trusts, community providers, primary care networks (PCNs), and mental health providers. In West Sussex, ICPs will also include organisations and bodies which span populations, such as district and borough councils, the voluntary sector, schools, the police, and other providers of health and care.

ICPs will be an alliance of "sovereign" providers, designed to integrate care around our local population, improve health and care outcomes and address health inequalities. Accountability for setting up ICPs will reside with our local providers. They will work closely with CCGs and LAs to provide a framework which supports partners to ensure delivery of improved outcomes in line with our joint delivery plan for West Sussex.

Across Sussex, we will work as a system to deliver high quality specialist and complex services to improve outcomes and reduce inequality. This will require us to work "at scale" to plan, to share best practice and deliver the best care. Individual hospitals will work together to provide the best quality, safety, value and equity of care in a timely manner; specialist centres will be developed for more complex services (such as stroke); and we will manage some of our essential supporting services, such as digital, workforce and estates, at a Sussex level, to deliver the infrastructure required to support continuous quality improvement.

One of the areas where we will work at scale across Sussex and at place is mental health. Colleagues across West Sussex have made some significant contributions to the SHACP Mental Health Programme. Mental health features strongly in the NHS LTP with the creation of new ring-fenced funding of £2.3 billion a year nationally. West Sussex has developed its own Mental Health Programme Board to oversee the transformation of key work streams such as Patient Flow, ensuring strong connections across a broad sector.

We are actively engaged in the prioritisation of the MHIS for Sussex and will be working closely with our partners in health and social care to ensure that West Sussex strengthens the provision of services which require a local approach. For example, we will invest in transforming community services with a focus on supporting people to get the support they need, when they need it close to home. Suicide Prevention is already making traction across West Sussex with specific activities focussed on our local population crossing the traditional boundaries of health and social care.

At place, we will be supporting people in our communities presenting at A&E with mental health needs to receive the best possible support through developing Core 24 Psychiatric Liaison Service in our acute hospitals, following a successful bid for £1.2 million of additional investment awarded to West Sussex. We will also be working with our colleagues across Sussex to ensure that our place-based approach to Improving Access to Psychological Therapies is enhanced through local connections to supporting people with LTCs.

3.4 Anchor Institutions

Much of what we will do over the next 5 years is in recognition of position of NHS and LA organisations in West Sussex as “anchor institutions”. Anchor institutions are large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area – they are effectively ‘anchored’ in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land.

Anchors have a mission to advance the welfare of the populations they serve. They tend to receive (or are significant stewards of) public resources, and often have a responsibility to meet certain standards on impact or value. These characteristics mean that our public sector organisations in West Sussex are well placed to have a powerful voice in where and how resources are spent locally. Public sector organisations can make a difference to local people by:

- Purchasing more locally and for social benefit
- Using buildings and communities to support communities
- Spreading good ideas and being models for civic responsibility
- Reducing environmental impact
- Widening access to quality work

4. Our Care Model

4.1 Population Health Approach

We will take a population health approach to improving the health, care and outcomes of people within the framework set out in the NHS LTP. We know a lot about our populations and an important part of our approach is to continue to develop and deepen this understanding through our work with local communities and through ongoing system analysis.

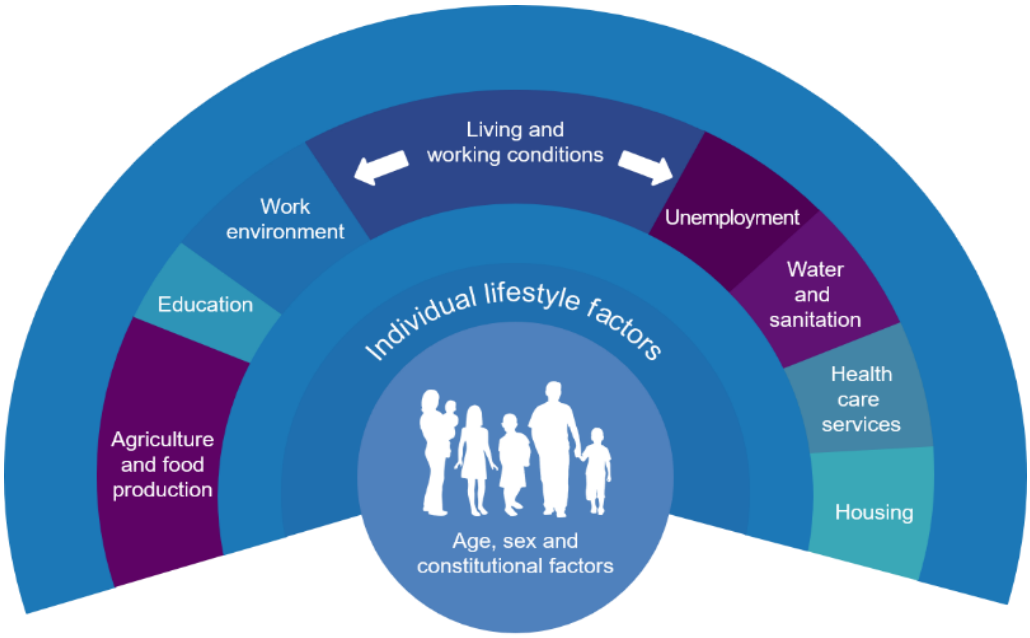

Figure 2: A population health approach for West Sussex

Population health is aimed at improving the health of the entire population, by improving physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities. It includes actions to reduce the occurrence of ill-health, addressing the wider determinants of health, and broader work with partner agencies and local communities.

Whilst our strategic framework for a population health approach is well-developed, our plans for delivery of the care model set out at Figure 3 are not yet adequate. The complexity of the change journey and the degree of transformation across our system will require the development of an infrastructure capable of supporting all partners across West Sussex to work towards improving outcomes. A plan to deliver the key components of a population health approach will be established by September 2020 as part of the joint delivery plan and this process will be led by the Director of Public Health. This process will develop our priority areas for implementation; an engagement framework setting out how we will work with our communities; and an impact analysis.

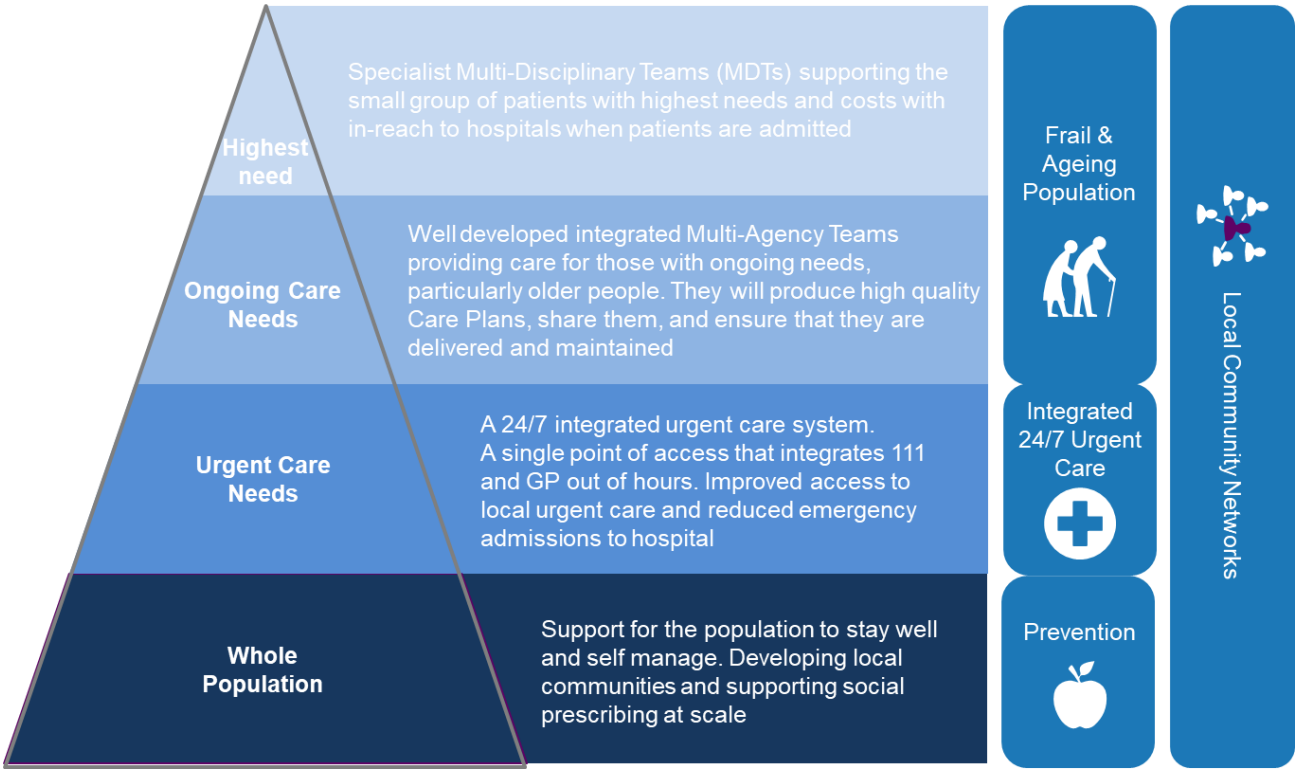

Figure 3: West Sussex Care Model

4.2 Whole Population

4.2.1 Overview

The NHS LTP sets out a clear commitment to increase action on prevention and health inequalities in the NHS. Delivery of these actions will complement existing population health approaches which are already being delivered across the health and care system by LAs, the NHS, Public Health England (PHE), NHS England (NHSE), and community organisations throughout Sussex.

We recognise that widespread cultural changes are needed in our public services to realise the full potential of such an approach, and this involves challenging existing ways of working. We know that if we are to be successful in delivering this approach then we will require bold leadership and a long-term strategic commitment to working differently with local people and communities. To build a new relationship with the public, there needs to be a shared way of working across all of the services operating in a place. A key part of this process will be harnessing LA leadership for key areas of our programme, such as prevention, and closer working between LAs, the NHS, voluntary sector organisations and others to establish a common approach.

Evidence from other areas suggests that it is possible to achieve substantial savings while protecting or improving outcomes, but only if services are genuinely transformed and upfront investment is available to help bring about new ways of working. A population health approach will not be a panacea, but it will provide the framework for a shift to a new model of public service delivery in which patients, service users and communities are involved as active partners in improving health and care.

To achieve our vision, and reduce health inequalities, our approach builds on existing work and sets the direction of travel for health and wellbeing across the county. Divided into three major themes: Starting Well; Living and Working Well; and Ageing Well, the Strategy takes a “lifecourse” approach to improving health and wellbeing as set out in Figure 4 below.

Figure 4: The "Lifecourse" Approach

4.2.2 Asset-based approach

We will be taking an asset-based approach to community development. An 'Asset-based' approach means that public services seek to build on the strengths and assets of individuals and communities to improve outcomes. Fundamental to asset-based working is a change to the nature of the relationship between staff delivering services and those in receipt of services. This shift is about working alongside people based on what will work for them, taking into account their individual circumstances and not assuming that public services

have all the answers. It is about 'working with' rather than 'doing to', and a focus on what service users 'can do' rather than what they 'can't do'.

The types of assets that can be harnessed to improve health outcomes include the following:

- **social assets**, based on relationships and connections with friends, family and neighbours
- **community assets**, including voluntary sector organisations working to improve health and wellbeing, and less formal groups such as book clubs
- **physical assets**, including parks and open spaces, libraries and leisure centres
- **personal assets**, including knowledge, skills, interests, talents and aspirations of individuals

The environment we live and work in can have positive and negative impacts on wellbeing e.g. access to good green spaces, high densities of alcohol and fast food outlets, the emphasis on driving and screen time at work and home. Our environment in West Sussex, natural and built, is a great asset; with historic coastal resorts, seaside attractions, beautiful countryside and lively market towns and villages. The natural environment has a big impact on our physical and mental wellbeing, so maximising health benefits of our environment is important.

In addition to the natural environment, there are over 325 schools; 80 GP practices; 160 community pharmacies; hospitals with A&E departments at Chichester and Worthing and additional NHS hospital sites across the county; 36 libraries; numerous museums, galleries, theatres and historic properties. The county has a large number, and variety, of organisations, groups and associations, fundamental in the delivery of services that support health and wellbeing; supporting individuals, families and communities, enhancing the vibrancy and quality of life in the county.

4.2.3 Neighbourhoods

Our approach will focus upon establishing our "neighbourhoods" as the fundamental unit of care co-ordination. Each will have an attributed population of 30,000-50,000 and will be supported by PCNs, where primary and community teams work with communities and individuals to promote and look after their health and wellbeing. Neighbourhoods will be the focus for prevention, choice, and self-care, and supporting people to make choices about their care and look after their own health priorities. They will focus upon addressing primary behavioural (smoking, drinking too much alcohol, unsafe sex), metabolic (high BMI, high cholesterol), and environmental (air pollution) risks.

Each neighbourhood will be supported by a PCN. The PCN will establish a wider primary care team made up of local GPs, nurses, social workers, pharmacists and the voluntary sector. They will meet often and seek input from a range of other specialist health, social care, community and public services as and when required. Each neighbourhood will have a set of priorities based on the health and social needs of their particular area and may work with other neighbourhoods in West Sussex where the opportunity to work at scale benefits the delivery of outcomes.

Our joint delivery plan will include specific goals for particular groups – for example, greater continuity of midwife care for black, Asian and minority ethnic women and women from deprived groups; an increase in physical health checks for people with severe mental health problems; and investment in meeting the needs of rough sleepers and ensuring better access to specialist mental health support.

Our commitment to our population within the framework of this neighbourhood approach is set out below in Figure 5.

Figure 5: Our commitment to neighbourhoods

4.2.4 Prevention

The recent government policy document 'Prevention is better than cure' (2018) sets out a call to action for prevention to be at the heart of everything we do.

"*Prevention cannot be solved purely by the health and social care system alone. Everyone has a part to play, and we must work together across society. This includes recognising the responsibilities of individuals and families in reducing the chances of becoming unwell in the first place, but also how the wider environment we live in determines our health*".

This is reiterated by the NHS LTP's positive shift towards prevention and reducing health inequalities and in the social care green paper, "Advancing our health: prevention in the 2020s – consultation document", published in July 2019.

Local government public health teams have been working in collaboration with NHS partners to embed prevention into the work of the SHACP. The Population Health Check set out an overview of the population health challenges and opportunities across Sussex, and identified key priority areas. It identified that 75% of deaths and disabilities across Sussex are caused by five conditions – cancer, circulation and respiratory disease, diabetes, bone and joint conditions, and mental health conditions – and these cause the biggest impact on our residents' quality of life and local services.

The Population Health Check also highlighted that "*prevention requires prioritisation and investment across the system*" and recommended the establishment of a vehicle to drive forward whole system engagement in the prevention and wellbeing agenda. A key outcome of the PHC is the establishment of a SHACP Prevention Board that will provide structure and governance for greater collaboration and action on prevention priorities across Sussex.

The purpose of a Prevention Board will be to improve healthy life expectancy and reduce dependency on health and care services through a radical upgrade in prevention, early intervention and self care. The board will provide structure and support to enable system wide change through:

- Maximising impact on outcomes by ensuring a well-co-ordinated and robust approach to prevention across Sussex, where it makes sense to do so.
- Driving forward a population health approach and a common understanding of health and wellbeing needs and evidence based interventions across Sussex.

- Supporting appropriate prioritisation of prevention across the activities of the SHACP.
- Joining up input of PHE, NHSE and Local Government Public Health to SHACP prevention to harness our efforts for maximum effectiveness.
- Providing a focus on wider determinants of health and link into primary, secondary and tertiary health prevention.
- Providing a vehicle for matrix working prevention across the STP governance structure.

The board will not seek to manage the entirety of prevention activity that is already underway, but focus on the added value from working together across Sussex where there are opportunities to do so at scale. This may include, for example, taking a common approach to smoking, alcohol, physical activity and diet across our NHS trusts.

Our Health and Wellbeing Strategy for West Sussex sets out the local priorities and how, working with local partners and residents, it is proposed that these are tackled. Partners in West Sussex will develop a "place-based" plan for prevention in West Sussex for September 2020 as part of the joint delivery plan. The plan will show how we will coordinate prevention activities across the county and within public sector organisations to deliver our local Health and Wellbeing Strategy. A prevention ethos will be championed locally, to change the culture towards prevention, promote personal responsibility for health and wellbeing, and to challenge inequalities. We recognise that it is important to clearly articulate what we understand by the term prevention, as we are aware that it is a frequently used word but can mean slightly different things to different people.

Ideally, we would want to prevent, remove or reduce any risk to health (primary prevention). Where that is not possible efforts should be made to enable early identification and treatment with the aim to cure, slow progression or reduce impact (secondary prevention). Once a problem or condition has arisen the task is to address complications (tertiary prevention) but at this point the condition may be persistent and treatment more costly. These stages of intervention are described in Figure 6.

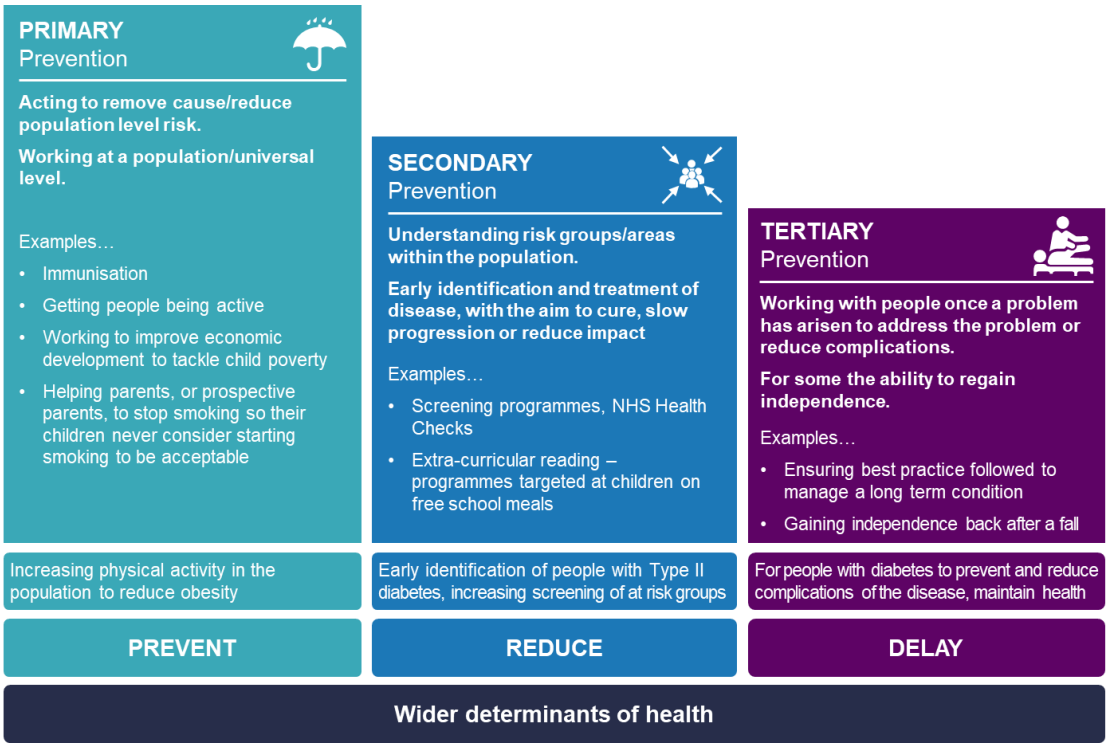

Figure 6: Prevention framework

The NHS LTP identifies five areas (smoking, obesity, alcohol use, air pollution and anti-microbial resistance) where funding will be made available to support prevention through the implementation of specific activities. We will ensure that these clearly link with, complement and boost existing activities, local priorities and objectives; and use existing oversight structures, groups and partnerships. We will work together with partners to ensure that objectives and activities are appropriate, supported and promoted at neighbourhood, place (West Sussex) and ICS (Sussex) levels.

A key local partnership promoting prevention at scale, across the county, is the West Sussex Wellbeing programme. This is a partnership between WSCC and the 7 local district and borough councils offering support and advice to all adults who live and work in West Sussex. This comprehensive programme is offered within each local council addressing health inequalities through targeted prevention programmes addressing local need, and is designed to reach those who are the least engaged to access support.

West Sussex Wellbeing provides a reach into the more deprived communities and incorporates work on key behaviours of smoking, alcohol, diet, physical activity and health and wellbeing checks. It works with local businesses to reach working age adults and supports and promotes leadership at a local level. It also ensures that assets in the local community are maximized, including leisure provision, cultural activities and the work of the local community and voluntary sector. It will provide the framework for our response to the five areas highlighted in the NHS LTP as follows:

Smoking – the Smokefree West Sussex Partnership has set out a detailed "Tobacco Control Strategy (2019-2022)" which contributes to meeting the national objectives through the co-ordinated effort of a wide range of partners. The strategy builds on national plans which establish tobacco control as a comprehensive and coordinated effort to reduce demand, prevent uptake, and support cessation rather than a focus solely on the delivery of smoking cessation services. Using the Department of Health's 10 High Impact Changes to achieve tobacco control, the strategy outlines a collaborative, solution-focused approach across the partnership and commits to a detailed set of actions, identifying interventions that impact across the wider determinants of health for the next 3 years.

Obesity - healthy weight is highlighted in the JSNA and in our Health and Wellbeing Strategy and links closely with the first priority of Start Well which concerns emotional health and wellbeing of our children. However, West Sussex has yet to commit to taking a coordinated, systematic approach to tackling this complex, multifactorial issue. In October 2019, a paper will be provided to the Health and Wellbeing Board which recommends that they endorse a new strategic approach, beginning with the establishment of a Healthy Weight Steering Group which is intended to report into the Health and Wellbeing Board. The group will consider the available evidence and work collectively to develop sustainable, universal approaches to prevent obesity in all children, ensuring there are pathways in place to support those who are obese or overweight.

Alcohol use - the West Sussex Alcohol Network includes partners from health, local government, and the voluntary and community sector. It explores opportunities to make the alcohol care pathway more effective and aims to plan joint responses to national campaigns. The focus for the Network will be to introduce early identification and intervention with primary care, to ensure that people are identified and supported at an earlier stage. Working with other local authorities in the ICS, we are pursuing the introduction of Alcohol Care Teams and, using DrinkCoach, we will ensure that there is online Alcohol Identification and Brief Advice, and via a Skype service extended brief Interventions for increasing or higher risk drinkers.

Air pollution - the Sussex Air Quality Partnership was established to support local authorities with their duties under Environment Act 1995 and implementation of the United Kingdom Air Quality Strategy. The Partnership has formed a West Sussex Inter Authority Air Quality Group (IAAQ) the IAAQ has an action plan which includes developing a public information campaign, working with developers through planning processes to include electric vehicle charging points, and looking at feasibility of differential parking charges and additional air quality monitoring on pay and display machines. In the context of the NHS LTP and recognition of the NHS as an "anchor" institution, the IAAQ is also engaging with NHS organisations to expedite actions on adopting sustainable practices, including use of energy, water and plastic; waste production and waste management; and travel, which requires fossil fuels and contributes to air pollution. The West Sussex Air Quality Needs Assessment (2018) was completed to inform the local air quality strategy (Breathing Better) and this strategy sets out the local priorities and actions for the county.

Anti-microbial resistance - the West Sussex Health Protection Group, a multi-organisational group including CCGs, PHE and LAs is aiming to establish an antimicrobial strategy as part of its scope of work in 2019/20. CCGs in the north and south of West Sussex have infection review action groups that focus on the reduction of Health Care Acquired Infections (HCAIs). We will continue to work collaboratively to reduce all avoidable infections, vaccine preventable disease and antimicrobial resistance.

4.2.5 Social Prescribing

A further example of our effective joint working towards a prevention ethos is the launch of social prescribing, under a co-ordinated 'Going Local' model. It is focused on people aged 18+ with underlying complex social, emotional or practical support needs. We also introduced two targeted social prescribing initiatives:

- Getting back to independence and reducing reliance on health care
- Confident connections – increasing confidence leading to better self-care

In 2019/20 we will seek to develop a coherent social prescribing approach that is aligned for the whole of West Sussex, with shared outcomes, while allowing for local flexibility to respond to specific population needs. Our ambition for 2020/21 is to ensure there is a link worker in place supporting each neighbourhood.

4.2.6 Making Every Contact Count

Making Every Contact Count (MECC) is "A Health in All Policies" (HiAP) transformational approach, based on the foundation that every day there are millions of interactions between public service workers and the public. It is an approach that enables individuals and organisations to develop a different way of working with people to promote and support health and wellbeing. Telling people what to do generally does not work. MECC is about being more attuned to how we interact with people and learning how to spot opportunities to talk to people about their health and wellbeing. MECC enables workforces to:

- Utilise a holistic, person-centred approach to service delivery
- Deliver 'very brief' or 'brief' evidence-based interventions for lifestyle behaviour change, as outlined in the NICE Guidance on Individual Behaviour Change focusing on the key elements of stopping smoking, drinking alcohol sensibly, increasing physical activity, maintaining a healthy weight and diet and promoting emotional health and wellbeing (Five Ways to Wellbeing)

- Know about local support services and how to signpost people to them where appropriate

MECC related skills are transferable and can be used within a workplace health context. The pressures faced by LA, NHS and voluntary sector workforces are well known, and MECC offers a pragmatic solution to scaling up a transformational shift toward prevention as part of organisational culture change. MECC can equip workforces at all levels to be more confident in discussing lifestyle related issues with each other as well as the people they work with.

4.2.7 Connecting Communities

Tackling loneliness and social isolation is an agreed Health and Wellbeing Board and national priority. There are many services and organisations carrying out work that impacts on this area and the evidence base around promising approaches is characterised by putting frameworks and processes in place to support connectivity rather than recommending specific activities / services.

A task and finish group has been convened to scope this area. It has received feedback on proposed approaches from the Public Health Board and from the Health and Social Care Board Business Planning Group and a detailed action plan supporting development is in place. As with other public health approaches to specific topic areas, action is being proposed at population, community and individual levels as set out below.

Tackling Loneliness and Social Isolation (L&SI)		Intervention	Description	Outcomes
Population	Ageing Well communications campaign 'Connect, Get Checked, Get Active'	WS Connection Confederation & Kitemark	Using Dementia Alliance approach – major WS organisations sign up for best practice Connection Kitemark e.g. running volunteer schemes, creating social spaces	Number of West Sussex organisations with Connection Kitemark
		Connection Conversations	Delivery of joint D&B and WSCC listening events across the county to identify local issues, what works and reduce stigma	Identification of issues and what works locally Reduction in stigma
Community		Targeted interventions for key at risk groups	Work with local groups to address needs of at–risk groups (e.g. bereaved with LTCs) including those identified in Connection Conversations	Reduced levels of loneliness and social isolation in at-risk groups
		Local resources	Production of a resource for members, & councillors outlining key actions to reduce loneliness at local level	% of councillors evidencing actions to reduce LSI

Individual		Production and dissemination of E-learning module	Improved knowledge and skills (for both professionals and residents) using a MECC approach to reach, understand and support people affected by L&SI	% of people taking module evidencing use of reach / understand / support approach

4.2.8 Supporting the development of PCNs

Improving care outside hospitals is one of the headline commitments in the NHS LTP. Alongside PCNs, the plan commits to developing 'fully integrated community-based health care'. This will involve developing multidisciplinary teams (MDTs) working across primary care and hospital sites. Over the next 5 years, all parts of the country will also be required to increase capacity in these teams so that crisis response services can meet response times set out in guidelines by the National Institute for Health and Care Excellence (NICE).

The 80 GP practices across West Sussex have organised themselves around 19 PCNs. Our PCNs will enable greater provision of preventative, proactive, personalised and coordinated health and social care. They will provide the leadership, resource and capability for wider primary care teams to support communities, ensuring that the framework for population health is delivered effectively.

Care will be needs-based, will include flexible access to advice and support for 'healthier' sections of the population, as well as joined up multidisciplinary care for those with more complex conditions. There will be a focus on population health including well-being, prevention, self-care, self-access, signposting, and supporting people to make choices about their care. There will also be a drive to improve the work life balance of people who work in general practice, through networks of practices and teams that bring community and primary care teams together to focus on neighbourhoods.

West Sussex is well set up to support the development of PCNs, learning from the work done over the last few years in developing Local Community Networks (LCNs) and Communities of Practice (COP). In preparing to provide the network services from April 2020, our PCNs are focusing on developing their teams through piloting a range of integrated services such as wound care and leg ulcer clinics. By doing this, PCNs will have built up their capacity to provide the network specifications once they are published in early 2020. Our plans for the development of services in support of these specifications assumes that we will achieve full delivery of the Network DES by the beginning of 2021/22 and that PCNs will be in a position to participate actively within ICPs and be ready to operate as providers in their own right by the end of 2020/21.

The Network DES requires practices to set themselves up as PCNs with a nominated bank account, a Clinical Director, and a signed agreement between the network practices. All practices in West Sussex have met the DES requirements and are providing Extended Access hours as a PCN. A number of PCNs have employed clinical pharmacists and social prescribers. Our Clinical Directors have met as a West Sussex group and have committed to share good practice. We also have a clinicians' advisory group that focuses on supporting Clinical Director and PCN development.

4.3 Urgent Care

4.3.1 Overview

The NHS LTP includes a significant package of measures aimed at reducing pressures on A&E departments. Many of the measures build on previous initiatives, including the introduction of clinical streaming at the front door to A&E and the roll-out of NHS 111 services across the country.

The model for urgent care in West Sussex has been developed over time with engagement across partners, including patients and public. It has adapted as the national steer has become clearer, particularly around NHS 111 and Out of Hours (OOH). The national specification for Integrated Urgent Care (IUC) was published in August 2017 and mandates NHS 111, clinical assessment services (CAS) and Home Visiting to be procured together to ensure integrated provision and a better experience for people. The model has been adapted and a wider programme is in place which includes commitments set out in the NHS LTP to:

- Roll out urgent treatment centres (UTCs) by April 2020 so that urgent care outside hospitals becomes more consistent
- Improve the advice available to people over the phone and extend support for staff in the community by introducing a multidisciplinary CAS as part of the NHS 111 service in 2019/20
- Rapid improvement in access to urgent care pathways to address issues impacting upon constitutional performance
- Consistent provision of same day emergency care (SDEC)
- Improved outcomes for those with mental health problems presenting in crisis, focused on resilience in communities and in alternatives to admission to hospital
- And opportunities to free-up acute hospital beds, including greater investment in discharge to assess (D2A) and greater levels of reablement

4.3.2 Integrated urgent care

A great deal of work is underway to improve the responsiveness of our community services. Our ambition is to provide safe, high-quality care to our population, operating as a fully bookable service, and placing greater emphasis on the use of alternative supporting services for minor injuries and ailments.

In West Sussex we have committed to rolling out UTCs by April 2020. UTCs will be GP-led facilities and will include access to some simple diagnostics and offer appointments bookable via NHS 111 for people who do not need the expertise available at A&E departments. They will be introduced at both Worthing and St. Richard's Hospitals by December 2019 and will be fully compliant with national standards from April 2020. Crawley will remain as a UTC, meeting national standards by December 2019. Bognor, Horsham and Queen Victoria Hospitals will become integrated primary and urgent care sites with an expectation that a model for these services will be agreed and fully operational from April 2021.

Alongside this, we will improve the advice available to people over the phone and extend support for staff in the community by introducing a multidisciplinary clinical assessment

service (CAS) as part of the NHS 111 service to be introduced in West Sussex from April 2020.

We will also support PCNs and developing ICPs to deliver a wider framework for community based urgent care, designed to increase the number of people receiving treatment in the out-of-hospital setting, through:

- Improved access to GPs and other local clinicians through clinical navigation hubs
- Increased community diagnostics to reduce demand on hospital-based diagnostic services
- A paramedic practitioner model supporting patients to be seen at home and reducing the need for conveyance to hospital
- Improved response for people with mental health problems including crisis cafes and safe havens to divert those in a crisis from unnecessary attendance at A&E
- Delivery of recommendations for our ambulance services further to the recent review of operational performance led by Lord Carter

A comprehensive delivery plan for further improving community response in a crisis and setting out our priorities for delivering this will be established by September 2020 as part of our joint delivery plan.

4.3.3 Same Day Emergency Care

Our A&E departments in West Sussex will introduce SDEC or ambulatory emergency care. This will see some patients admitted from A&E undergo diagnosis and treatment in quick succession so that they can be discharged on the same day, rather than staying in hospital overnight. Nationally, the NHS LTP estimates that up to one-third of all people admitted to hospital in an emergency could be discharged on the same day by rolling out this model.

SDEC services treat a wide range of common conditions including headaches, deep vein thrombosis, pulmonary embolus, pneumonia, cellulitis, and diabetes. The types of conditions that can be managed through SDEC will vary depending on the hospital and needs of the local population.

In West Sussex we will:

- Provide SDEC services at least 12 hours a day, 7 days a week by the end of March 2020
- Provide an acute frailty service for at least 70 hours a week by the end of March 2020, working towards achieving clinical assessment of frailty within 30 minutes of arrival in hospital
- Establish a ‘Rapid and Early Assessment for Cardiac Treatment’ (REACT) service and day-case angioplasty (PCI) service at Worthing and St. Richards Hospitals to reduce admissions and prevent clinically unnecessary overnight stays from December 2019

4.4 Ongoing Care Needs

4.4.1 Overview

PCNs will develop multi-agency teams to provide integrated care and support for people with ongoing care needs. The first priority for these teams is to develop high quality care plans for

people identified as having severe or moderate frailty. PCNs will be supported to deliver this integrated approach with data solutions designed to enable segmentation and risk stratification.

A programme of work has also been established across West Sussex to support more people in their own homes or in a community setting. This programme includes:

- A responsive service community model to deliver “Home First” and D2A provision
- Rapid response for admission avoidance and early supported discharge (ESD) for those who have had a stroke
- Acute and community teams working with social care and the voluntary sector to improve patient flow through hospital
- Improved support to care homes to reduce the number of residents who are taken to hospital and admitted as emergencies

4.4.2 Step Up Step Down

Improving patient flow and reducing delayed discharges remains a priority in West Sussex. Alongside ongoing initiatives such as “Trusted Assessment” and the “Let’s Get You Home” campaign, a programme has been established which sets out a Step Up Step Down (SUSD) model for West Sussex designed to support delivery of an integrated discharge and admission avoidance service covering 6 weeks prior to and post an acute episode combined with single streamline access.

The vision is to deliver an integrated health and social care team with the right skill mix to maintain people in their own homes avoiding acute hospital admission when possible as well as discharging patients with the appropriate support following admission. This will consolidate available resources across health and social care to place people at the centre of service delivery. An integrated team should enable skill development, cross cover and support between current disparate teams.

For the purposes of this programme, SUSD services are defined as specific community based health and care services and interventions which work directly to achieve one or more of the following objectives:

- Acute admission avoidance at the point of clinical need for acute care
- Early supported discharge after acute admission
- Longer-term avoidance of unplanned hospital admission
- Reduction in the use of home care services
- Avoidance of admission to long term care

The model will be delivered in three phases as follows:

- **Phase 1** – ‘Step-down’. Consistently deliver the nationally recognised D2A four pathway model (October 2019) and formation of Integrated Discharge Teams
- **Phase 2** - Align 6 weeks post discharge services with joined up front door and admission avoidance services to include:
    - co-location (April 2020)
    - a change of response criteria for all admission avoidance referrals to be classified as urgent with a target of phone or visit within 2 hours (April 2021)

- alignment of referrals to a single point of access (SPoA) (April 2021)

- **Phase 3** - Provision of fully integrated SUSD services (January 2021)

We have defined short, medium and long term aims (2022/23 onwards), all of which align to the overarching principle of delivering sustainable community crisis and reablement services for the next 10 years. We expect that our plans will:

- Reduce functional decline and improve outcomes for those requiring inpatient care
- Improve flow and increase weekend discharges by 25%
- Increase the number of people returning home directly from hospital
- Reduce length of stay for complex frail patients

Within the scope of this programme we will also work to understand the capacity and demand for a West Sussex community health crisis response service and a reablement service and the alignment of both initiatives to standardised metrics. This analysis will be completed by February 2020.

Developing Enhanced Health in Care Homes

Plans for PCN development across West Sussex includes provision of enhanced health in care homes (EHCH) from April 2020.

A range of support for people in care homes has been developed over recent years as follows:

- Locally Commissioned Services (LCSs) where GP practices receive additional payments to provide an enhanced primary care service
- Community nursing support providing training for care home staff; targeted support for homes identified as having higher needs; specific support designed to reduce unplanned admissions and 999 calls; training around end of life identification; and care homes are being supported to register on NHS.net
- Pharmacists who provide medication reviews for residents of care homes

To deliver EHCH and to improve this core support offer, we are developing our Proactive Care MDTs to support integration with general practice. This model:

- Defines a target population of frail and elderly in receipt of integrated multi-disciplinary care (inclusive of care-home residents, in line with requirements of EHCH framework)
- Devises a system by which the target population is consented into community MDTs
- Defines a set of proactive interventions to be delivered by general practice and community MDTs
- Requires general practice and community MDTs to develop a system for organising more accessible and coordinated community response to those with escalating needs
- Aligns both operational requirements and incentives between Sussex Community Foundation Trust (SCFT) and practices to create a framework for integration around PCNs
- Aligns with the current LCS for care homes

4.4.3 Falls Prevention

Falls prevention is one of the priority areas in the Ageing Well component of our Health and Wellbeing Strategy. Therapeutic strength and balance exercise programmes are the key intervention for those at low to moderate risk of falls and an important part of the treatment of those at high risk. They have been shown to reduce the number of falls by around a third and the number of people falling by a fifth. Group strength and balance has also been shown to increase overall levels of physical activity and can reduce loneliness and social isolation. At the same time, interventions can be delivered improving the opportunities for strength and balance promoting physical activities ranging from ball and racquet sports to muscle strengthening activities using free weights, bands or machines. There is also the opportunity to support an increase in strength and balance in activities of daily life.

Currently all West Sussex districts and boroughs deliver strength and balance exercise programmes and leisure services provide a range of physical activity opportunities. The ambition is to continue to increase quality and integrate strength and balance for falls prevention into an overarching physical activity framework for mid and later life.

4.4.4 A Carer-Friendly NHS

Support to carers in West Sussex centres around the “Joint Commitment to Family, Friends and Carers 2015-2020”. This is supported by:

- The Family and Friends Carers’ Care Pathway which provides a generic pathway for incorporation into all patient and customer care pathways and hospital admission/discharge procedures, to help health and social care staff in identifying, recognising and supporting carers
- Carers Support West Sussex which provides county-wide advice, information and support to adult carers, is the reception point for all carers’ services in West Sussex, and enables carers to access relevant support services
- The Carers Health Team, which supports carers over the age of 18 to develop individual strategies with an aim to reduce the strain of coping with their caring role and, if it is necessary, also look at the health needs of the person who is being cared for and the bereaved

Through our joint delivery plan we will raise the profile of carers, achieve personalised support to carers, ensure young carers can achieve education and employment, support carers to remain physically and mentally well, and build a carer friendly community.

4.4.5 Respiratory

West Sussex has developed plans to improve the delivery of respiratory care, by focusing on respiratory care in the community.

In the north of West Sussex a plan has been set out to redesign respiratory pathways. The aim of these pathways is to ensure that that admissions from respiratory conditions can be reduced by effective management of different levels of complexity across primary care, general and specialist community services.

In Coastal West Sussex (CWS), a comprehensive community respiratory service is being implemented. The first phase, implemented in 2019/20, will see Home Oxygen Assessment and Review becoming available to all patients receiving long term home oxygen. Phase two will explore a redesign of the current COPD and pulmonary rehabilitation service. Longer term, our aim is for the service to be able to provide community support to people with a

wide range of respiratory-related conditions, reducing the need for these people to have to travel out of the area for specialist aftercare.

4.4.6 Personalised Care

The NHS LTP expects systems to set out how they will use the funding available to them to implement the six components of the NHS Comprehensive Model for Personalised Care as set out in Universal Personalised Care.

Personalised care is increasingly important as our population want more choice and are often experts in their own care. They expect clear information about what treatment involves, the evidence that it works, the outcomes it will achieve and what happens next. Across West Sussex there are plans in place to deliver many of the six components of the NHS Comprehensive Model for Personalised Care. This includes:

- **Shared decision making** - a focus on establishing shared decision making for elective care services including Musculo-skeletal (MSK) services as a priority first step and work with LAs to further develop plans for those with a LTC and/or in need of continuing health care
- **Personalised care and support planning** - plans for personalised care and support planning to be developed with local authorities within the framework of the F.A.C.E. model
- **Enabling choice, including legal rights to choice** – with a focus on developing and enhancing a single referral pathway, a referral support service for elective care, and designing follow up services that allow patients to opt in and out as their needs change options
- **Social prescribing and community-based support** – building on existing social prescribing initiatives with a coherent social prescribing approach aligned for the whole of West Sussex
- **Supported self-management** – we will use digital solutions such as MSK Assist to support people to build knowledge, skills and confidence and to live well with their health conditions. We have introduced a pilot project in partnership with NHSE/I and local providers to test the value and efficacy of supported digital self-management. The allocation of NHSE funded myCOPD online subscription licenses will be offered free, by NHS clinicians, to eligible patients with COPD. Evaluation outcomes include:
    - Improving knowledge, skills and confidence to self-manage their long term condition
    - Improve health outcomes, including reducing exacerbations
    - Improve local health economy outcomes, by reducing avoidable GP appointments and avoidable emergency admissions
- **Personal health budgets (PHBs) and integrated personal budgets** - spending more on PHBs in 2019/20 compared to 2018/19; provide training for PHBs; and increasing work with the LA to develop their plans to increase the number of PHBs

There is also work to be done in conjunction with LAs to develop and agree a detailed set of deliverables for the NHS Comprehensive Model of Personalised Care as part of our joint delivery plan. There is work in place to ensure that PCN members are aware of each other's role and responsibilities in relation to delivering these services, and there will be a workforce plan within each PCN to review capacity, skills and support needed to deliver the new services as a network.

4.4.7 Elective care

We will also begin the process of redesigning our elective care services. This programme will focus on:

- A review of pathways for major diseases and long term conditions
- New integrated pathways in areas such as MSK, which will redesign the relationship between GPs and secondary care clinicians to one where it is easy to get advice in real time and to improve care earlier in the pathway
- Minimising activity with limited clinical value in line with the Clinically Effective Commissioning (CEC) programme and Low Priority Procedures (LPP) guidelines and policies
- Improving referral support for GPs
- And enhancing the productivity of acute and out of hospital planned care capacity – through virtual clinics, direct to test referrals, one-stop clinics and clinical hubs, and ensuring effective treatment first time to avoid the need for follow up appointments

West Sussex is currently piloting First Contact Practitioners (FCPs) for MSK, and we plan to roll out services across the county from April 2020.

Outpatient Redesign

The NHS LTP includes an ambitious pledge to use technology to fundamentally redesign outpatient services over five years. The aim is to avert face-to-face consultations in order to provide a more convenient service for patients, free up staff time and save money against the expected growth in demand.

The plan requires systems to set out how they will increase the use of digital tools to transform the ways in which outpatient services are offered and provide more options for virtual outpatient appointments. System partners in West Sussex have committed to working together to deliver an outpatient transformation programme.

Our programme recognises there are opportunities to deliver transformation at all key touch points in the patient's elective care pathway including advice and diagnosis, follow up care after a hospital procedure and ongoing specialist care for long term conditions.

Some outpatient redesign pilots are under way for a limited number of specialty areas and these will be evaluated on an ongoing basis. We will be working with providers to identify which specialties will be prioritised across 2020/21. We know that Western Sussex Hospitals NHSFT (WSHFT), for example, will prioritise orthopaedics, urology and ophthalmology. This process will be complete by March 2020 and we will establish a programme of work which will see the implementation of one stop and straight to test pathways, virtual clinics, SOS follow up and the use of alternatives such as telephone or Skype. This process will also include modelling to assess the impact of a reduced number of face to face visits, to include an assessment of capacity against expected growth over the next 4 years.

More specifically we will see:

- The first stage implementation of digital outpatients by providers during 2019/20, deploying access to letters and appointments through an STP-wide Personal Health Record solution.
- Development and implementation of a Sussex Wide Dermatology service

- Conclusion and implementation of the of the Sussex Wide Head and Neck Review
- An integrated MSK model for CWS including a single point of access with clinical triage, shared decision making, promotion of conservative treatment options in line with CEC policies and supported self-care enabled by digital solutions such as Patient Know Best
- A recurrent service model following evaluation of the Virtual Fracture Clinic pilot at Surrey and Sussex Healthcare (SaSH)
- Transformation of ophthalmology pathways including AMD and glaucoma
- A pathology optimisation programme consistent with “Choosing Wisely” principles to reduce the number blood tests identified as either of limited clinical benefit, not required, should only be consultant initiated or requiring specific intervals between tests
- Provider implementation of the opportunities identified by the FourSight Theatre Efficiency programme in ophthalmology, general surgery and ENT

We will continue to work across the system and with the Sussex Outpatient Transformation Board to enable the delivery of outpatient transformation across Sussex. More detail on the system-wide outpatient plan is available in the Strategic Delivery Plan.

Cutting waits for elective care

In West Sussex, the time that patients have waited for elective treatment has increased and we are not compliant with NHS constitution targets. This has been one of the most difficult operational issues over recent years, impacting on the experience of many patients waiting for treatment.

We will develop a demand and capacity plan by the end of December 2019 showing how, over 5 years, a combination of the system efficiencies and transformation programmes outlined above, and increases in the volumes of some planned activity will reduce long waits and cut the number of people on the waiting list.

We will aim to improve patient experience, quality and responsiveness of elective provision to:

- Expanding the scope and uptake of Advice and Guidance on E-RS and working with providers to agree service specifications and response times and that consultant time to respond is reflected in job plans
- Delivering the next phase of clinical policy development via our CEC programme which aims to ensure access across Sussex is consistent, in line with the latest clinical evidence and represent the most sensible use of limited resources
- Working within the national Evidence Based Interventions (EBI) Demonstrator community to ensure effective implementation of relevant national Evidence Based Interventions and their next phase of policies
- Working across Sussex to implement a system wide solution for prior approval to deliver overall reductions in the number of interventions not routinely provided and improved adherence to evidence based clinical policies.
- Exploring how to establish community diagnostic and training centres for X-ray, CT, MRI, ultrasound, and bone scan and barium swallow services.
- Continuing to focus on demand management, through:

- Implementing the “Capacity Alerts” system
- Further development of our referral support service, including peer review via PCNs
- Improving referral support for GPs

- Implement a single referral pathway for all specialty areas by the end of 2020/21

We will take a Sussex-wide approach to offer choice of alternative provider to patients who have been waiting more than 26 weeks. A Sussex Delivery Group has been established, including commissioners and providers, to develop a Standard Operating Procedure, source capacity and set up a central ‘administrative hub’ to manage the process. We expect to be able to commence a small scale pilot in December 2019, roll out of priority specialty areas for some patients in January 2020, with full implementation for all providers for all pathways by March 2020.

We will also take specific actions to enable achievement of the diagnostic standard including:

- a demand and capacity review of non-obstetric ultrasound and implementation of a single delivery approach across Sussex by end of 20/21
- Implementation of a revised threshold for faecalprotectin resulting in fewer face to face appointments and endoscopies
- extending the scope of FIT tests to include high risk patients resulting in decreased demand endoscopy through an initial pilot in CWS
- Working with the Cancer Alliance to deliver Rapid Diagnostic Services

Planned NHS-Managed Choice Process

The NHS LTP requires systems to implement a planned NHS-managed choice process for all patients who reach a 26-week wait. In West Sussex, the NHS-Managed Choice Process will be fully implemented for all providers and for all pathways by March 2020. This will be a commissioner responsibility and the CCGs will review Referral to Treatment (RTT) 25 week waits on a monthly/fortnightly basis.

This will be supported by the referral support service in the north of West Sussex and the single referral pathway in CWS, which both contain functionality to ensure that all patients waiting more than six months for their elective treatment are proactively contacted.

4.5 Highest Needs

4.5.1 Overview

Our neighbourhoods have a small number of people whose needs are greatest and who require high levels of care and support. These people will also have a high quality care plan and will be supported by a local MDT team which may operate across more than one PCN. Specialists will have a direct role in care planning and delivery and will also have an important role in supporting the wider team with training, advice and support.

When people require inpatient care the aim is to maintain continuity with the local specialist team through in-reach, communication and joint planning, to minimise the time people need to spend in hospital and ensure safer discharge.

4.5.2 Providing 'Anticipatory Care'

In the north of West Sussex we have developed COP which are providing elements of anticipatory care for a defined population. These are MDTs that provide wrap around community support to the most frail populations. Latterly, these teams have re-configured around PCNs.

Within the Network DES for PCNs, GP practices and other providers of community services will work collaboratively to introduce more proactive and intense care for people assessed as being at high risk of unwarranted health outcomes, including people receiving palliative care. Our plans for PCNs set out an intention to deliver the specification for anticipatory care from April 2020 within the framework of the F.A.C.E. model (Find, Act, Care, Evaluate) set out at Figure 7 below.

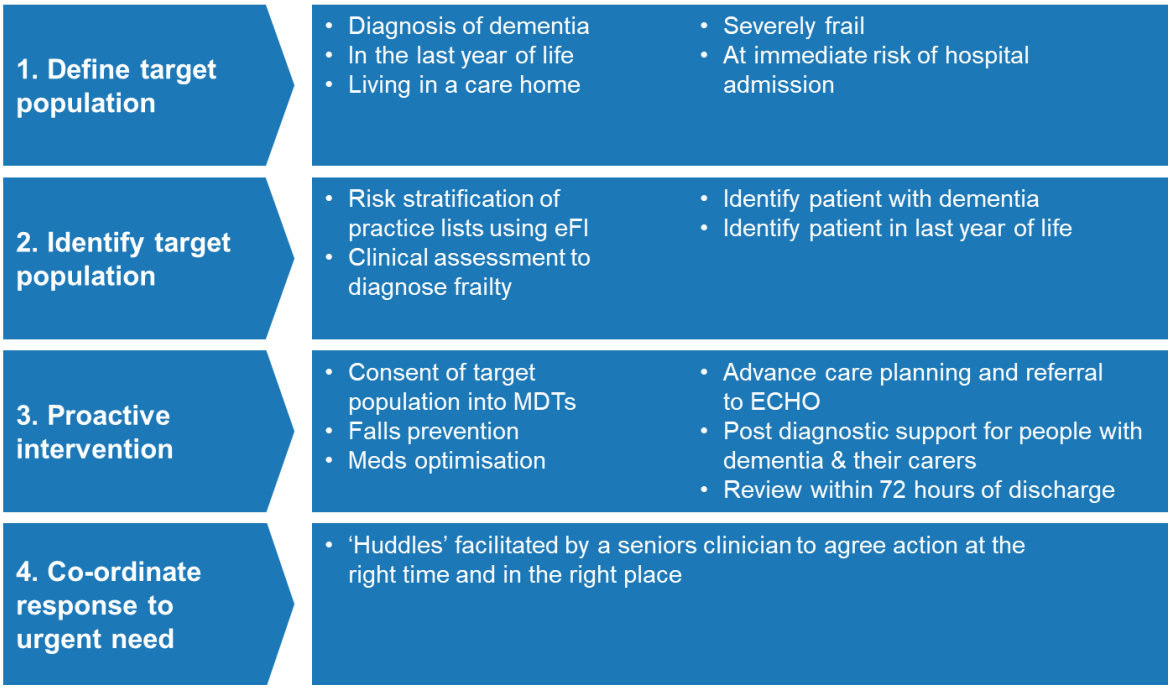

Figure 7: FACE Model

4.5.3 End of life care

End of Life Care (EOLC) continues to be an integral part of our priorities for West Sussex.

Our Health and Wellbeing Strategy includes the goal that people in West Sussex receive good quality end of life care and have a good death. The aim is to build compassionate communities across the county, where people are able to have conversations about living and dying well and to support each other in emotional and practical ways in times of crisis and loss. We need to work together with our partners across the county if we are going to make this a reality.

Many people whose deaths are predictable are not being identified as being in the last year of life. This means that their care needs are often not being met or identified. This may lead to avoidable use of emergency inpatient care and a significant proportion of EOLC patients dying in hospital. There is also evidence that a large percentage of the care home population is in the last 2 months of life, yet care homes are not always consistently able to manage deterioration and dying patients.

Compassionate communities are an asset-based approach to EOLC developed with communities themselves. They support people who are dying and their families, as well as people who have been bereaved, and improve people's health and wellbeing at times of crisis and loss. They help people to plan ahead and make choices, talk more openly about death, dying and bereavement, and care for people at the end of life and after death. Compassionate communities do not replace health and care services but work together with them to enable people to have a good life till the end and a good death.

In West Sussex we have many assets which we can build on – including our hospices which are delivering elements of this approach, Gold Standard Framework-accredited care homes, dementia-friendly communities such as Crawley, the ECHO hub in the south of the county, a strong voluntary and community sector, and increasing identification of people in the last year of life in primary care.

Our initial scoping work has identified the need for community engagement as a priority to understand people's views and experiences of death, dying and bereavement, and what a compassionate community means. Over the next 12 months our focus will be on 3 work streams: community engagement, stakeholder engagement, and identifying resources and capacity to deliver the work programme.

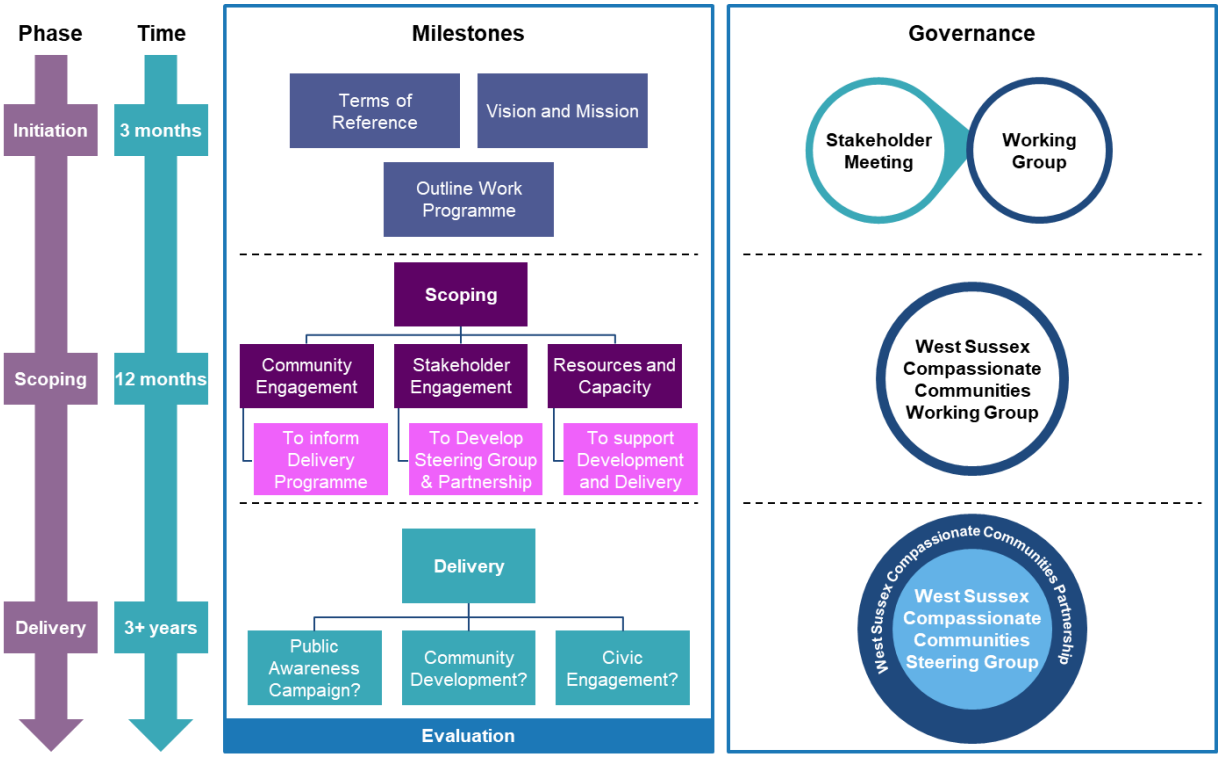

Figure 8: Compassionate Communities work programme

Building on the success of ECHO (83% of ECHO patients with a known preference died in their preferred place) we will also continue to improve care for those in the last year of life and their carers by:

- Increasing timely identification of the end of life care needs
- Reducing the rate of short-stay non-elective admissions in the last 12 months of life
- Reducing the proportion of deaths occurring in hospital

To do this we will develop a programme of work by March 2020 to:

- Expand our PHBs to those receiving specialist end of life care
- Personalise care, working with patients, families, local authorities and our voluntary sector partners at both a national and local level, including specialist hospices
- Roll out training to help staff identify and support relevant patients, introducing proactive and personalised care planning for everyone identified as being in their last year of life
- Continue to embed the ‘ECHO’ pathway in our emerging PCNs through the FACE model
- Embed the GP QOF QI and participate in PCN activities to regularly share learning
- Deliver improved co-ordinated personalised anticipatory care within primary care
- Continue to embed ‘Planning Your Care’ process across PCNs
- Support development of EHCH by commissioning of relevant skills and training

5 Children and Young People

In West Sussex, we understand that the first few years of life are a key period in which the actions of our parents, carers and those around us influence our physical, emotional and mental health in later life. Our earliest experiences of life, starting in the womb, through pregnancy and birth and into our early years, are vital in laying the foundations for our future health and wellbeing. Research consistently shows that even short term improvements in physical development (i.e. obesity and physical activity), cognitive development (i.e. school achievement), behavioural development (i.e. antisocial behaviour) and social/emotional development can lead to benefits throughout childhood and later life.

In West Sussex, the proportion of children and young people within the overall population has remained relatively stable over the years, certainly in comparison to older people. However, what has changed rapidly is the sort of society and problems that children and young people face, the increase in children being referred to agencies, and the complexity of the children that our services are working with. Our challenge is to adapt to this growing complexity and support parents, carers and families, providing universal services but also targeting resources at those most in need, and those at risk of poorer outcomes, narrowing the inequality gap . This requires systematic approaches to prevention, good communication, appropriate data sharing, working with a range of partners, at all stages of childhood, and in a range of settings.

Our Health and Wellbeing Strategy for West Sussex sets out our priorities for the improvement of services for children and young people (CYP) with a focus on a “start well” approach. Our goals, as set out in the strategy are as follows:

- **Improved infant and maternal outcomes especially in deprived areas** - we can help ensure the best start in life for babies by working to reduce smoking in pregnancy and to address the causes of low birth weight, infant mortality and poor maternal mental health
- **Children, young people and families have good emotional wellbeing and mental health** - we will support children, parents and carers to achieve and maintain good mental wellbeing and to reduce mental health problems
- **Children grow in a safe and healthy home environment with supportive and nurturing parents and carers** - parenting is critical to children’s experience of early years and their life chances. We will work to support parents in creating a healthy and safe home and learning environment that nurtures their children, to ensure strong parent-child attachment and positive child development, as part of our parenting offer
- **Children and young people leaving care are healthy and independent** - we will work to ensure comprehensive pathways and care packages are available to support care leavers.

The key initiatives supporting delivery of our strategy are:

- Sussex and East Surrey Local Maternity System Transformation Plan– set up to improve services and support for pregnant women, babies and their families
- 1001 Critical Days: Vulnerable Pregnancy Pathway – delivering a connected multi-agency vulnerable pregnancy pathway and new guidance
- Whole schools approach - to build resilience and improve health and wellbeing outcomes for all pupils

- Healthy Child Programme - framework of universal and progressive services for children and young people to promote optimal health and prevent ill health
- Find It Out Plus - an integrated hub approach to emotional wellbeing and mental health for young people
- Family Assist - digital support for families pre-birth to 19 years (25 years SEND). Currently focuses on pregnancy to 2 years
- Corporate parenting - everyone working with, or representing the interests of children and young people in care is a corporate parent. All local authority staff, elected members and relevant partner agencies share this duty
- Sugar reduction - working alongside other initiatives to tackle childhood obesity
- Apprenticeship scheme - support the development of an apprenticeship for care leavers

We know that there are gaps in the current provision of NHS children's services across West Sussex that are currently being supported by temporary arrangements that are not sustainable. We have workforce constraints; pathways into and out of services that are not always clear; we have no formal arrangements for acute commissioning; our multi-organisational working is in need of development and creates the potential for fragmentation; our leadership for strategic development is unclear and our plans are not adequate. Our priorities for the next 12 months, therefore, will be:

- Developing a shared improvement plan for NHS children's services reflecting commitments set out in the Health and Wellbeing Strategy and showing how we will improve performance in areas such as childhood screening and immunisation programmes and how we will meet the base level standard in the NHS public health functions agreements
- Developing a clear strategic plan including an understanding of investment and resources and our priority areas for change to ensure delivery of NHS LTP commitments, with a specific focus on:
    - Developing age-appropriate integrated care
    - Integrating physical and mental health services
    - Enabling joint working between primary, community and acute services, and supporting transition to adult services
    - Improving care for children with long-term conditions, such as asthma, epilepsy, diabetes, and complex needs
    - Treating and managing childhood obesity
    - Supporting the expansion of CYPs mental health services
    - Improving outcomes for children and young people with cancer.
- Integrating our offer across both the NHS and LAs to ensure local leadership; an engagement strategy which will underpin co-production with children, young people, families and carers; and a clear view of expectations of our services and the outcomes for children and young people

6 Enablers

6.1 Workforce

People are at the heart of the system that we are building. We recognise that recruiting and retaining our workforce in a geographical area which has a high and increasing percentage of older people, a current workforce with large numbers close to retirement and a decreasing percentage of younger people joining the workforce, is a critical issue both now and in the future. With these anticipated demographic changes we will have to think strategically and differently to ensure that we have the workforce we need to deliver care. This will require us to think creatively about roles and ways of working. Refining our workforce plans to ensure a sustainable workforce aligned to our vision is therefore a priority, alongside developing a framework in which strong leadership creates a culture where people want to stay, thrive and develop.

The NHS LTP calls for a 'fundamental shift' in the way that the NHS works alongside people. With leadership from WSCC, we will focus on developing an assets-based approach to creating genuine partnerships between professionals and people in receipt of care and support, and we will establish a programme to train staff to be able to have conversations that help people make the decisions that are right for them.

Our local priorities are based on the need to support sustainable delivery today, and strengthen the foundations and planning that will enable the workforce to support and deliver the vision for the future. The key elements of our work programme in West Sussex are:

- Partners working together to identify and resolve immediate workforce pressures and opportunities to stabilise the current system in West Sussex. This includes reducing the use of temporary staffing, working on urgent issues such as GP recruitment, and work place wellbeing initiatives, including tackling burnout
- Supporting the vision for West Sussex through workforce modelling and planning that will enable us to refine current plans to redirect our focus and work to deliver at scale and pace, in relation to both the capacity and capability of the collective workforce
- Developing a Workforce and Organisational Development Strategy by September 2020 to support our joint delivery plan, which will describe how we will support the transition and establishment of new ways of working and describe how we will support and develop individuals and teams that can work together to deliver the new care model
- Developing the conditions for change with a communications framework to truly engage and enthuse our staff
- Designing a workforce development programme that will enable the leadership needed to deliver real change and to develop people in line with our vision

6.2 Digital and IT

Digital technology underpins some of the NHS LTP's most ambitious patient-facing targets and is a key enabler to the delivery of the new models of care, supporting staff to work differently, improving access to advice for patients and the public, harnessing data to inform decision making, and through telehealth solutions, driving productivity improvements. Patients have also told us that they increasingly expect to be able to use digital technology to interact with health and care services. Digital technology will also facilitate service transformation, including the redesign of outpatient services and reorganisations of pathology and diagnostic imaging services.

The development of a shared care record is an immediate priority in West Sussex and one which will support delivery of the commitment that people will be able to access their care plan and communications from health professionals and support the "right" set out in the NHS LTP for people to have access to digital primary care services. The shared care record will also support the following functionality:

- Provision of a shared record viewer so that authorised health and social care workers can see relevant care data from GPs and all other care providers at the point of care
- Support for the development of care plans and common assessments to be used and shared by the entire care community
- Support for clinical alerting and decision support across care providers
- Task management, clinical communication and referrals across care communities so that clinicians can ask for advice or support on-line
- Risk stratification and segmentation

To deliver 'digitally enabled care' as envisaged by the NHS LTP, we will work across Sussex to deliver a wider programme ensuring that all secondary care providers become 'fully digitised' by 2024. West Sussex will also deliver digital transformation of primary care. It is a key deliverable that all GP practices are technically enabled to provide all the functionality that will be offered through the NHS App, as part of the Digital Primary Care transformation plan to ensure it is available to 100% of the population by 31 July 2019.

Our specific priorities for digital transformation over the next 2 years are:

- Development of a fully interoperable record between providers via the Primary and Secondary Care interface project
- The roll-out of the NHS App, Online Consultations, and online booking into Integrated Urgent Care Services (Urgent Treatment Centres and Extended Access)
- Ensuring robust connectivity between primary care clinicians regardless of them working on a sessional or substantive basis

6.3 Estates

Ensuring that the estate is fit for purpose is key to implementing new models of care. Our approach will be based on the following assumptions:

- Elements of the current local healthcare estate, in particular GP and community premises, are becoming increasingly less suitable for delivering the new care model, and are increasingly expensive to run and maintain. To 'do nothing' with the estate is not a sustainable option.

- New models of care involve greater integration and co-ordination amongst a wider range of services, which impacts directly on the estate requirements of those services.
- Co-location and delivery of services at an optimised scale will bring significant benefits to the population in terms of shared facilities and resources in an accessible community location.

Our estate plan for West Sussex will seek to:

- Improve the suitability, quality and utilisation of the estate
- Dispose of surplus assets to support further re-investment in local care
- Rationalise the estate in ways which support wellbeing, effective networking, co-operation and integration of skills and resources
- Replace outdated, unsuitable and inefficient buildings and ways of working, with modern, flexible and effective work and care settings
- Reduce the environmental impact of the estate

6.4 Communications and engagement

The NHS is an institution that people trust. People have interacted with the NHS in similar ways since 1948, and we are asking staff, patients, carers and communities to change how they do that. This is a huge change and communicating what is happening, and when; and ensuring we are engaging with people is going to be vital in the delivery of the new care model.

Our plan is informed by the Sussex-wide “Our Health, Our Care, Our Future” public engagement. The key issues for West Sussex arising from this are:

- The large geographical area in West Sussex includes both urban and rural populations, some of which have health inequalities that need to be addressed
- A lack of transport in rural areas to support access
- Concerns over GP premises as some are of poor quality and unsuitable for disabled access
- Lack of awareness of urgent care options, including Improved Access
- Varying degrees of willingness to disclose mental health issues and subsequently access support
- The need for cultural awareness and service provision that reflects this
- A need to talk more openly about death and end of life care
- Issues with access to mental health support for children and young people
- Widespread support for social prescribing, and the need to build on and publicise existing assets in local communities

The next phase of our strategy is to develop a clear, compelling and credible narrative that will enable us to engage more widely with stakeholders. It will include independent facilitated focus groups with key audiences to:

- Create an early, important opportunity to begin a wider conversation with stakeholders involved in delivering the new care model

- Help us test our key messages about the new care model
- Give us insight on improvements` that our services need to make for local people
- Provide a platform for a wider programme of engagement with the public and other key stakeholders over the next six months and beyond.

We will use the insight from the focus groups and all the local data available to create a detailed and robust communications and engagement activity plan.