NHS
Coastal West Sussex
Clinical Commissioning Group

Adur & Worthing councils

west sussex county council

Sussex Community NHS
NHS Foundation Trust

Sussex Partnership NHS
NHS Foundation Trust

Western Sussex Hospitals NHS
NHS Foundation Trust

Coastal Care:

Inspiring healthier communities together

Our shared plan for Coastal West Sussex

19 October 2016

Draft

Contents

1 Executive Summary

1.1 Introduction

Coastal West Sussex has a population of 480,000, and with one in four people aged over 65, has one of the oldest demographics of any area in England. Coastal West Sussex is a historically high performing health and care system, with services delivered by stable and robust organisations and a track record of partnership working. However, services are not sustainable in their current form. **There is a clear case for change in Coastal West Sussex:**

1. **Demand for services is rising at an unprecedented rate** driven by lifestyle factors and through a growing and ageing population.
2. There is a **gradual deterioration in outcomes for local people**, and health and wellbeing gaps are widening.
3. **Feedback from patients and the public is that services are not joined up**. Increasingly people expect to use digital technology to interact with health services.
4. There is no real term increase in available NHS resources and spending on Adult Social Care and related Council Services is reducing in real terms. The **gap between available resources and projected spending requirements is expected to rise to £162m by 2020/21**, unless we act.
5. Opportunity is being lost to moderate demand. **The adoption of new ways of working isn't fast enough to overcome demand growth**
6. **Staff shortages in many parts of the system** combined with high turnover are placing services under severe pressure.

The Case for Change in Coastal West Sussex

1.2 Coastal Care: Inspiring Healthier Communities

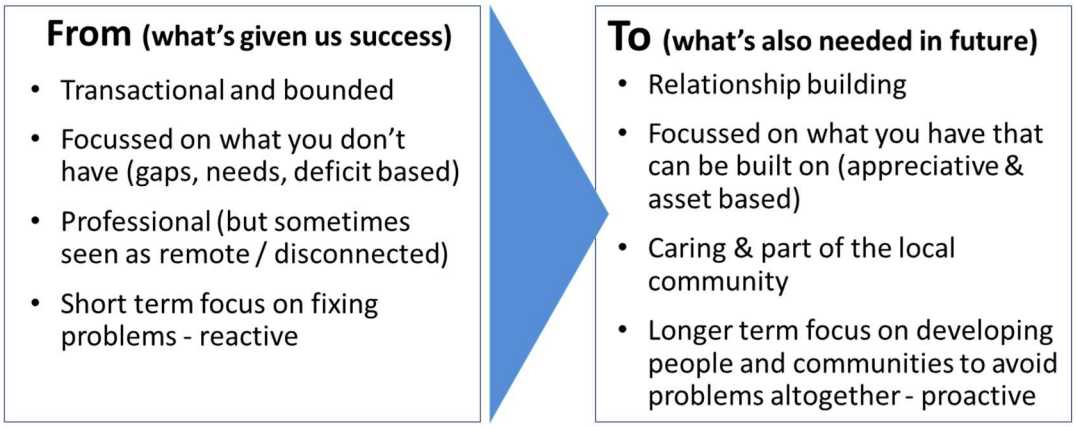
Coastal Care is the programme through which Coastal West Sussex Clinical Commissioning Group and its 49 member general practices, West Sussex County Council, local District and Borough Councils, Sussex Community NHS Foundation Trust, Sussex Partnership NHS Foundation Trust and Western Sussex Hospitals NHS Foundation Trust are working together to build healthier communities and to create sustainable health and care services for the local population. The Coastal Care Programme is fully aligned with the Surrey and Sussex Sustainability and Transformation Plan. Through the Coastal Care Programme:

- A **new model of care is being introduced**, which promotes physical, mental and social wellbeing, prevention and earlier intervention, and proactive integrated care to support those people at greatest risk
- An **Accountable Care Organisation for Coastal West Sussex will be established** by April 2018, breaking down organisational barriers and enabling the whole system to align around a common purpose, a single set of objectives and a single capitated budget.

Through these changes:

- The **health and wellbeing of the Coastal West Sussex population will be improved**
- The **quality of the care provided for the population will be improved**; outcomes and experience will be better
- **Efficiencies will be delivered**, reducing the gap between costs and available resources
- **Staff recruitment, retention and satisfaction will improve**

Our approach is summarised in the figure below



Biggest gap is cultural – changing the fundamental perceptions of staff and public from reliance / dependence to resilience / independence

1.3 The Coastal Care Model

Eight Local Community Networks (LCNs) form the foundations of the new Coastal Care Model, in which General Practices, community services, mental health services, secondary care clinicians and social care professionals work together and with local communities to integrate care around the needs of the local population. LCNs will promote the development of community networks, deliver prevention and earlier intervention, and work with people and communities as the co-producers of health and well-being, rather than the recipients of services.

Urgent Care will be redesigned across Coastal West Sussex, into a coherent and streamlined system that has an effective, clear single point of access and directs people to the most appropriate urgent care service for their needs. Each LCN will redesign the provision of urgent on-the-day primary care in their area. Appointments will be triaged in each LCN and clinical resources pooled, with a team of GPs, nurses, therapists and pharmacists seeing patients in an LCN hub. Where appropriate, alternatives to face to face appointments will be offered. In future most urgent care will be delivered locally, through the network of LCN hubs.

Care for older people and those with chronic conditions will also be transformed. The new care model works to provide proactive care and support as people's needs increase, with the aim of delaying and avoiding the progression of, or number of, conditions that individuals live with. Patients requiring proactive care and support will be systematically identified using risk stratification and case finding tools. Multi-disciplinary teams operating from local hubs will develop effective Care Plans with their patients. Care Plans will be electronic and easily shared within the MDT, with patients and across the system with other providers when necessary. New Coordinator/ Navigator roles will be developed in MDTs to be a point of contact for patients and carers and to ensure that their Care Plan is a live and relevant document. Specialists have a key role in supporting and advising the Core MDTs in the management of patients locally and the relationship between GP's and secondary care Consultants will be redesigned so that it is easy to get advice in real time using the telephone or internet.

1.4 Enabling the new model of care

Refining our **workforce plans** to ensure a sustainable workforce to deliver the new model of care is a key priority. A Workforce and Organisational Development Strategy is being developed which will describe how we will develop both a sustainable workforce for the future, and our Accountable Care Organisation. The strategy will be underpinned by a framework for change that supports the delivery of successful organisational change and a leadership development programme that will enable the system leadership needed to deliver real change and to develop people in line with our vision.

Technology is a key enabler to the delivery of the new models of care, supporting staff to work differently, improving access for patients and the public to advice, harnessing data to inform decision making, and through telehealth solutions driving productivity improvements. Patients and the public have also told us that they increasingly expect to be able to use digital technology to interact with health and care services. Investment to develop a shared care record during 2017/18 is an immediate priority.

Through the delivery of the Coastal Care **Communications and Engagement Strategy**, staff, patients, carers and communities will be fully involved in the design and introduction of the new models of care.

1.5 Establishing an Accountable Care Organisation

Introducing these new models of care requires high levels of collaboration between partners, integrated delivery and a shift of resources from hospital based care to primary and community based care. Organisational boundaries can get in the way of making this happen. There is widespread consensus that the current payment, contracting and organisational arrangements contribute to the fragmentation in the system, and don't support integrated population based care.

An Accountable Care Organisation for Coastal West Sussex will be established. This new approach will break down the current organisational barriers to create a system where local health and care partners collaborate to resolve the issues for the population, integrating care pathways to be more effective, and reducing bureaucracy and overhead costs.

The Accountable Care Organisation (ACO) will operate in shadow form from April 2017, and be fully operational by April 2018. The ACO will bring together responsibility for local primary, community, mental health and acute NHS care provision for the Coastal West Sussex population into a single organisation. West Sussex County Council will be fully aligned with the ACO. The ACO will hold a single, long term capitation and outcomes based contract with NHS Coastal West Sussex, and be accountable for delivery of a series of population health outcomes for Coastal West Sussex. This contractual arrangement will enable the CCG to evolve into a more strategic commissioning role, and with some functions currently managed within the CCG transferring to the ACO.

List based primary care is the foundation of the NHS and ensuring strong, redesigned, local primary and community care is crucial to the successful delivery of the new model of care. Our care model and financial plan is predicated on shifting resources from hospital based care to primary and community based care in Local Community Networks. It is proposed that individual GMS contracts continue to be held by NHS England, as in the current arrangements.

The Accountable Care Organisation, working with GP leaders, will work to develop and commission primary care as part of each Local Community Network.

A Shadow Accountable Care Board will be established, by 1 April 2017, which will:

- Take overall responsibility for delivery of health services for the Coastal West Sussex population. This includes being responsible for financial, quality, and operational performance at system level.
- Take responsibility for delivering year 1 (2017/8) of this Coastal Care Plan with specific emphasis on overseeing the development and implementation of the Local Community Networks and overseeing the delivery of the agreed Coastal West Sussex Financial Recovery Plan.

1.6 Financial Plan

The combined health and social care resources available for the local population totalled approximately £1,267m in 2016/17, comprising c£963m NHS funding and c£304m of social care for adults and children. The total NHS and social care resources available are expected to rise by c£160m to £1,428m by 2020/21.

However, the costs of delivering services in the current models will also continue to rise, as a result of increased demand and due to price inflation. Unless we act, the gap between available resources and costs is forecast to be £28m in 2017/18 rising to £162m in year by 2020/21.

The introduction of the new model of care, and the development of the Accountable Care Organisation are expected to:

- Reduce demand for health and care services in Coastal West Sussex
- Enable increases in productivity and efficiency, reduced waste and reduced transaction costs
- Enable a shift in resources from hospital based care to primary and community based care.

Initial, high level and first draft financial modelling suggests that the NHS financial gap in 2020/21 can be reduced from £134m to £51m through the actions set out in this plan. The total health and social care gap is modelled to reduce from £162m in 2020/21 to £75m. Further work, to model in more detail the implications of the model of care and the opportunities resulting from the introduction of an Accountable Care Organisation will take place over the next four weeks.

1.7 Implementation of the Coastal Care Plan

A programme implementation plan, Programme Initiation Document and Programme Governance arrangements are in place to deliver this plan for Coastal West Sussex. The programme priorities for the remainder of 2016/17 have been agreed and work to implement the new model of care and establish the Shadow Accountable Care Organisation by April 2017 is underway. The arrangements to establish the Accountable Care Organisation are being described in a Memorandum of Understanding which will be ratified by all partner organisations in Coastal West Sussex.

The Programme Logic Model (overleaf) summarises on one page the rationale, activities, outcomes and expected impact of the Coastal Care Plan.

COASTAL CARE PROGRAMME LOGIC MODEL

A Our CONTEXT and RATIONALE

Coastal West Sussex has a population of 480,000 people and one of the oldest populations in the country. Despite a strong track record, there is a clear and agreed case for change: Demand for services is rising at an unprecedented rate driven by lifestyle factors and through a growing and ageing population. There is a gradual deterioration in outcomes for local people, health and wellbeing gaps are widening, and feedback from patients and the public is that services are not joined up. The gap between available resources and projected spending requirements is expected to rise to £162m by 2020/21, unless we act. Opportunity is being lost to moderate demand. The adoption of new ways of working isn't fast enough to overcome demand growth. Staff shortages in many parts of the system combined with high turnover are placing services under severe pressure. **Coastal Care** is the programme through which the health and care organisations in Coastal West Sussex are working together to build healthier local communities and sustainable services. Eight Local Community Networks (LCNs) form the building blocks of the Coastal Care Community, bringing together and developing local services.

B With these INPUTS

- People from a range of organisations form LCN team and leadership
- LCN development programme
- Technology to support new model including shared record, SPOA and case finding
- Physical infrastructure investment in LCN hubs
- Support from county, district and borough councils for community asset mapping and development
- Staff from primary, community, mental health, secondary care and voluntary sector form MDTs
- New roles developed such as care co-ordinators/navigators and new roles in A&E
- Existing Board and executive infrastructure of Coastal Care partner organisations
- Evidence of what works, and local experience
- Strong local leadership, commitment and relationships to deliver the Coastal Care programme

C we will carry out the following ACTIVITIES

New model of care activities

Establishing Local Community Networks
- Development plan and timeline for each LCN, including forming a leadership team, governance and OD support
- Community asset mapping & community development
- Needs analysis to inform local priorities
- Implement prevention plan and social prescribing at scale
- Establish LCN hubs following option appraisal

Transforming services for an ageing population
- Developing and implementing standardised best practice for case finding, care planning and care co-ordination
- Core MDTs developing care plans for >10% of population
- Specialist MDTs supporting care plans for those with greatest needs
- Each LCN to redesign 2 pathways with hospital each year
- Re-ablement and support at home services developed for early discharge

Transforming urgent care
- Redesigned urgent on-the-day primary care appointments in LCN hub, with extended opening hours 7 days/week
- Single point of access that integrates 111 and out-of-hours primary care services
- Primary care stream in A&E

Enabling activities

Introducing a shared care record and digital technology to enable the implementation of the new model of care

Establishing an Accountable Care Organisation involving primary, community, mental health, acute and social care with governance that ensures accountability for the whole population via a capitated budget

Investing in leadership and team development and workforce redesign, enabling cultural and behavioural change

Engaging with staff and local people; fully involving them in the design and introduction of the new model of care

D Creating the following OUTPUTS

- 8 Local Community Networks (LCNs) established, with single leadership team in place for each
- Hubs established for each LCN
- Effective LCN governance arrangements established with good engagement of all services, public and stakeholders
- Prevention and social prescribing impacting on population
- Care plans in place for 10% of population with regular, well attended MDT meetings
- 2 redesigned pathways each year with more patients receiving care locally and more patients supported for earlier discharge
- All urgent primary care patients seen on the day in hubs. More patients seen by other members of the primary care team through face to face, telephone & web based consultations
- Primary care patients redirected from A&E & admissions avoided
- Urgent care calls routed through Single Point of Access and triaged
- Patients and clinicians able to access a shared care record wherever and whenever needed
- Accountable Care Organisation with one Board, one system plan and one operational model

E To deliver the following OUTCOMES

- Improved personal wellbeing
- Increased confidence of people to take responsibility for their own health and greater public confidence in the urgent care service
- Improved patient experience of care and services experienced as being 'joined up'
- Greater local engagement in care and services
- Improved mental and physical health outcomes
- Sustainable model of primary care, stabilised GP workforce, more time for GPs to spend with people with chronic conditions
- More care delivered at home or in the community, rather than in hospital
- Reduced demand through prevention and social prescribing
- Reduced hospital utilisation (A&E, admissions, readmissions, occupied bed days, outpatients, delayed transfers of care)
- Reduced annual costs per head of population
- Simplified planning, prioritisation and decision making, with reduced transaction costs
- Greater staff satisfaction, staff confidence and teamwork

F with these long term IMPACTS

- **Improved health and wellbeing** of the Coastal population
- **Improved quality of the care** provided for the Coastal population
- **Improved productivity & efficiency;** creating a financially resilient and sustainable system
- **Improved ability to recruit and retain a skilled and motivated workforce**

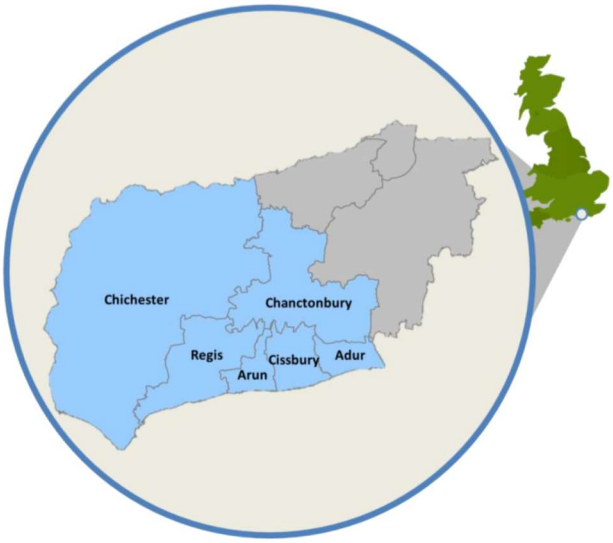
NHS Coastal West Sussex Clinical Commissioning Group · Sussex Community NHS Foundation Trust · Sussex Partnership NHS Foundation Trust · Western Sussex Hospitals NHS Foundation Trust · Adur & Worthing councils · west sussex county council

2 Introduction and case for change

This chapter describes the challenges facing health and care services in Coastal West Sussex and why we need a new approach to meet the needs of the population.

2.1 Introduction to Coastal West Sussex (CWS)

Coastal West Sussex has a population of 480,000 people living in coastal towns and rural villages in the central south coast of England. The area has one of the oldest populations in the country, with more than 25% aged over 65, and more people aged over 80 than most other areas in the UK.



Coastal West Sussex is a historically high performing health and social care system, with services delivered by stable and robust organisations and with a track record of partnership working. However, a number of trends mean that health and care services in Coastal West Sussex are not sustainable in their current form.

As providers and commissioners of health and social care in Coastal West Sussex, we share an ambition to improve the health of the population which has developed over the last 18 months. ***Coastal Care*** is the programme through which organisations are working together to build healthier local communities and to create sustainable health and care services in Coastal West Sussex. The programme involves:

- **Coastal West Sussex Clinical Commissioning Group**, the NHS commissioner for the Coastal population, and its 49 member GP practices
- **West Sussex County Council**, who provide council services to all of West Sussex and which has an aligned approach to Coastal Care
- **District and Borough Councils** in Coastal West Sussex
- **Sussex Community NHS Foundation Trust**, provider of community health services across West Sussex, Brighton & Hove and High Weald Lewes Havens
- **Sussex Partnership NHS Foundation Trust**, provider of mental health services in West Sussex, East Sussex, Brighton & Hove, Kent and Medway and Hampshire.
- **Western Sussex Hospitals NHS Foundation Trust**, provider of acute health services, with major hospitals in Worthing, Shoreham-by-Sea and Chichester.

In parallel with our local work, health and care systems across England are developing Sustainability and Transformation Plans (STP) to implement the *Five Year Forward View* in their local area. Coastal West Sussex is an integral part of the Surrey and Sussex STP. The plans set out in this document describe how we are implementing the Five Year Forward View, and the Surrey & Sussex STP, for our local population.

2.2 The challenge facing Coastal West Sussex: the case for change

Coastal West Sussex has, relative to other health and care systems, reasonable outcomes. Across a range of comparative measures services are judged mostly 'middle of the pack.' From a CQC perspective Coastal West Sussex has an 'Outstanding' acute provider, a 'Good' community provider, and a mental health provider 'in need of Improvement'. This however, doesn't tell the whole story. The true position can't be understood by taking a single 'snap shot in time' and only emerges when trends are looked at over several years.

In order to provide this more detailed understanding of our strengths and challenges, detailed analysis has been undertaken of the Coastal Care health and social care system.[1] Our analysis, which is summarised in this chapter, brings together currently available information sources that include population data, the CCG Outcome Framework, Commissioning for Value/ RightCare, General Practice data, and Adult Social Care data (including the Adult Social Care Outcomes Framework, data on domiciliary care and the care home/nursing home markets).

In summary, there is a clear case for change in Coastal West Sussex.

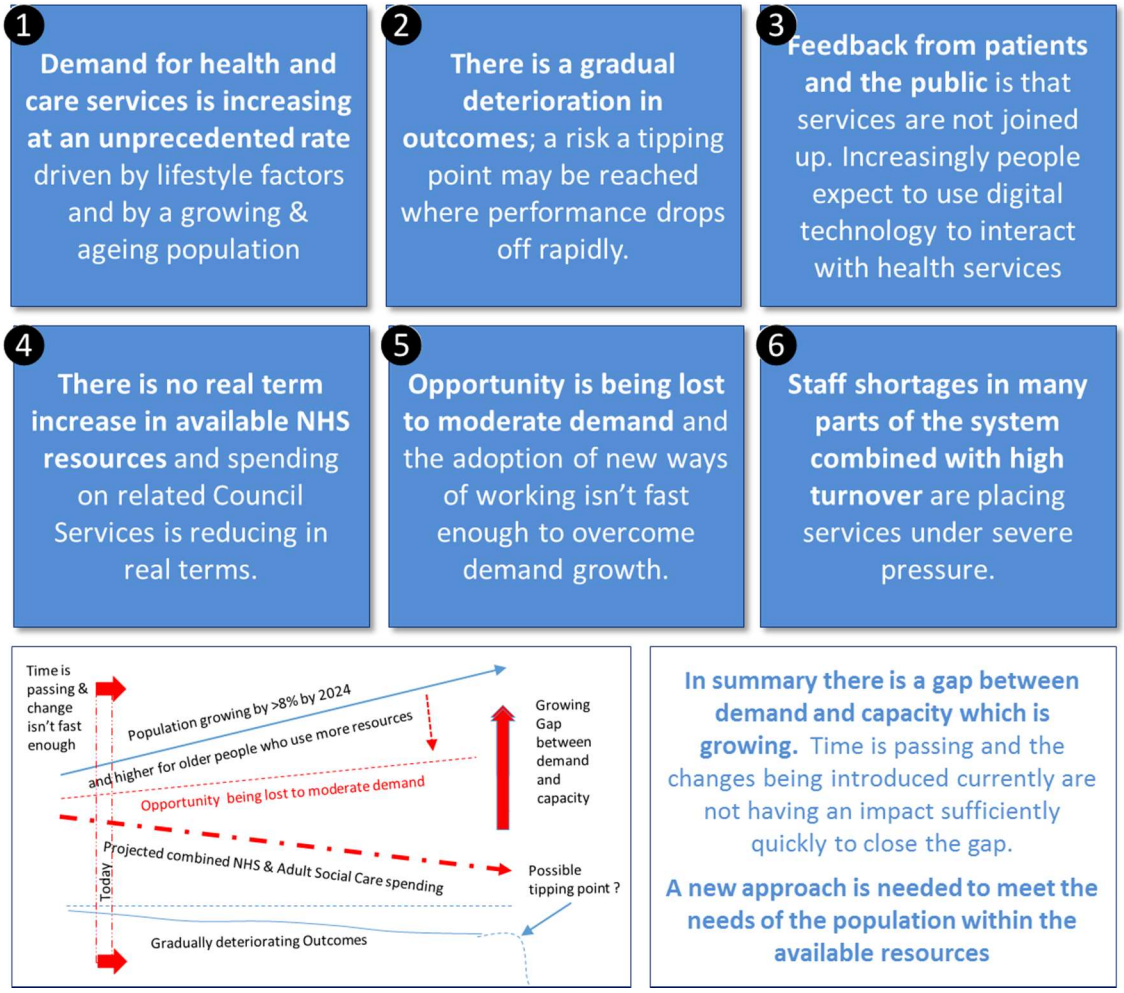
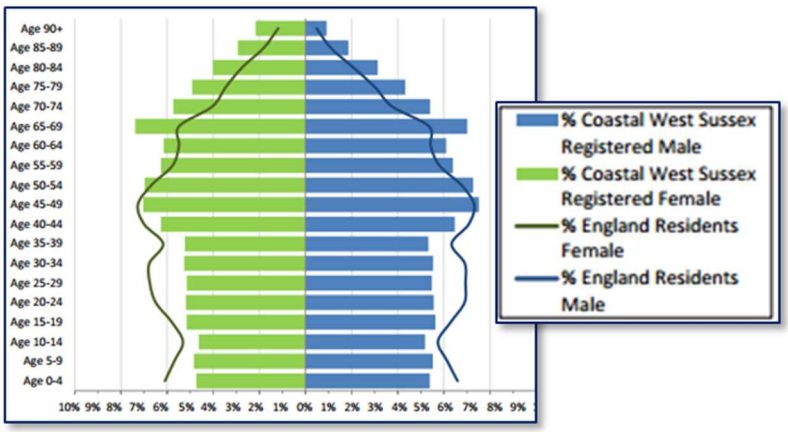


Figure 1: The case for change in Coastal West Sussex

Each of these themes is described in more detail overleaf.

[1] Coastal Care gap analysis, undertaken September 2016 and available on request.

Theme	Details
❶ **Demand for services is rising at an unprecedented rate driven by lifestyle factors and through a growing and ageing population.**	Coastal West Sussex has one of the oldest populations in England, with more people aged over 50 and over 80 than most other areas. Whilst we celebrate that people are living longer, an older population has higher levels of frailty and illness. Coastal Care's population is set to grow by more than 8% by 2024 with 65 to 84 year-olds growing by over 17% and those over 85 by more than 36%: the local population is getting larger and even older. 1 in 4 of the Coastal population has a Long Term Condition such as diabetes, dementia or lung disease. Lifestyle factors are also a key driver of demand. Around 80% of deaths in the Coastal population are from major diseases such as Cardiovascular disease, stroke and cancer, that are attributable to lifestyle risk factors such as smoking, excess alcohol & poor diet.  **Coastal Care's rapidly growing and ageing population will increase demand at one of the highest rates of any area in England.** To manage this older population Coastal Care needs to be one of the best in England at managing large numbers of older people with chronic diseases, multiple conditions and frailty. Coastal Care will additionally need an outstanding capability and capacity to help moderate unprecedented increases in demand. This includes encouraging more self-care, promoting better prevention/early intervention, and working with children and families to give the adults of tomorrow the best possible start.
❷ **There is a gradual deterioration in outcomes for local people, and health and wellbeing gaps are widening.**	Across a range of outcome indicators, Coastal West Sussex has a good position relative to other areas and has seen some improvements in a number of domains. However, trends over time show an overall picture of deteriorating outcomes. For example, indicators relating to potential years of life lost in the population, under 75 mortality for cardiovascular disease and cancer, and emergency admissions for alcohol related liver disease all show a general degradation. Whilst performance is relatively good compared to other health and care systems, there are opportunity to reduce deaths due to cancer and to save costs if the system were able to perform at the same level as the best of similar health and care systems. In particular there are opportunities to improve chronic disease management and the holistic management of patients. There are also wide inequalities between the communities that make up Coastal with some local neighbourhoods having a life expectancy over 10 years shorter than their neighbours. As demand is increasing at an unprecedented rate, the general strain on the health and care system is having an adverse impact on some critical outcomes, and the current relatively good 'snapshot in time' of outcomes is not sustainable.

❸ **Feedback from patients and the public is that services are not joined up. Increasingly people expect to use digital technology to interact with health services.**	Feedback from patients and the public provides a mandate for change. Patients tell us that health and care services are not joined up, that communication between services is poor, and that they increasingly expect to be able to access information and communicate with the NHS using digital technology. Coastal West Sussex CCG conducted a large scale survey to capture the views, wishes and suggestions of local people. The survey explored people's reactions to changes to primary care services, including the desire for continuity of individual GPs, the need for extended hours, use of digital technology, the potential of visiting nearby GP surgeries and seeing other professionals. It also looked at people's awareness of and choices of urgent care services. More than 6,000 responses were received. Patients would like to have better access to primary care – commenting about the length of time it takes to get a routine appointment and the difficulties of getting an urgent 'on the day' appointment. There is a clear sense that people prioritise seeing their own doctor for long term conditions, but are happy to see a different doctor if it is faster for new or immediate problems. Older people, those with long term conditions, people with physical disabilities, and higher users of services emphasise continuity more than younger people who visit GP practices less often. There is support from local people for seeing specialist doctors or specialist clinics and urgent appointments at other local practices/ locations and to undergo tests and procedures which would otherwise mean going to hospital. For urgent appointments, there is a relatively high level of acceptance of seeing advanced nurse practitioners, physician's associates or paramedic practitioners. Two thirds would like to be able to communicate with their GP by email, and there is some support for texting and video conferencing. These options are more popular with people of working age. Patient feedback also confirms that there are opportunities to improve the management of long term conditions.
❹ **There is no real term increase in available NHS resources and spending on Adult Social Care and related Council Services is reducing in real terms. The gap between available resources and projected spending requirements is expected to rise to £162m by 2020/21, unless we act.**	The NHS now provides an increasingly more extensive and sophisticated range of treatments and procedures, and new drugs, technologies, standards and treatments are typically more expensive than the approaches that they replace. Given the wider challenging economic environment for the UK, the economic outlook for the NHS and social care system is the most difficult it has faced. The combined health and social care resources available for the local population totalled approximately £1,267m in 2016/17, comprising c£963m NHS funding and c£304m of social care for adults and children. However, the costs of delivering services in the current models will continue to rise, as a result of increased demand and due to price inflation. As a result, the gap between available resources and projected spending requirements is expected to rise to £162m by 2020/21. This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms. Nationally gross expenditure on domiciliary care is reducing, whilst the average hours of domiciliary care per person per week is increasing. This implies there is a shift in 'complexity' of people receiving domiciliary care with a 'richer mix' of people with greater needs within this client group. Like many parts of England Coastal Care may now be seeing more people falling out of the LA funded care system. This has the potential to push the overall care system into a counterproductive scenario that saves money now at the expense of creating more higher acuity demand later.

5 Opportunity is being lost to moderate demand. The adoption of new ways of working isn't fast enough to overcome demand growth

The analysis undertaken to support this plan highlights evidence that there could be more management at the front of the pathways, particularly those related to chronic conditions. There is considerable variation between practices in both recorded vs estimated prevalence and emergency admissions associated with the management of long term conditions. Those practices with a large gap between estimated and recorded prevalence &/or high emergency admissions may have an opportunity to improve their long term condition management.

Coastal West Sussex has higher readmissions associated with COPD and hypertension than the national average and some of its individual areas have much higher rates than others and frequently higher than the CCG and West Sussex averages.

The latest nationally published data suggests WSCC have been heavily committing to self directed support and direct payments at much higher levels than the national and cluster average, whilst simultaneously falling behind in areas such as keeping significant types and numbers of service users in stable employment and accommodation, and have fallen below the national and/or cluster average in providing re-ablement.

6 Staff shortages in many parts of the system combined with high turnover are placing services under severe pressure.

Sussex Community NHS Foundation Trust, Sussex Partnership Foundation Trust and Western Sussex Hospitals Foundation Trust have a combined workforce of 15,000 and a vacancy rates of around the national average of 10%.

Coastal West Sussex faces serious recruitment challenges which threaten to undermine local services. Nurses, GP's, Occupational Therapists, Social Workers and Care Support staff in both domiciliary and residential care are all difficult to recruit. High turnover, particularly in the first year of employment, is costly and disruptive to service provision. Reducing reliance on a temporary workforce is a key driver for all providers although the true expenditure is difficult to establish. The challenge for employers is to create an environment and a culture that makes people feel valued.

There is a capacity gap in General Practice which isn't resolvable by recruitment alone, and a new approach is needed. Despite being in a relatively good position compared to other systems (see table below), projected demand for primary care is greater than that which practices are able to deliver.

Detailed breakdown for STP	Total No. of GPs & Nurses	GPs & nurses per 1,000 pop	% GPs & nurses Over 55	% GPs and nurses Over 65
NHS Eastbourne, Hailsham and Seaford CCG	165.06	0.88	20.3%	1.7%
NHS High Weald Lewes Havens CCG	114.85	0.70	22.0%	1.7%
NHS Coastal West Sussex CCG	443.03	0.91	21.7%	0.9%
NHS Crawley CCG	101.85	0.80	24.6%	2.4%
NHS Horsham and Mid Sussex CCG	194.01	0.85	23.2%	1.5%
NHS Hastings & Rother CCG	158.55	0.86	32.6%	2.6%
NHS Brighton & Hove CCG	185.19	0.63	19.4%	2.5%
NHS East Surrey CCG	146.77	0.84	24.0%	0.4%

There are also significant emerging workforce gaps in Adult Social Care. Across South East England the largest workforce group in adult social care are unqualified care workers who have a 28% turnover. Due to the increasing complexity of clients needs, more of these care workers need to be trained to a high standard as personal assistants. However, at the moment, a third of all care workers receive no regular and ongoing training. The shortage of nurses directly impacts on care/nursing Home closures.

There is, therefore, a compelling case for change in Coastal West Sussex. Chapter 3 of this plan sets out our vision for Coastal Care, to address these challenges and ensure the sustainable provision of high quality care for the local population.

3 Our vision and the impact we want to have for local people

This chapter describes what we are aiming to achieve, and the benefits this will have for our population and for our health and care services.

3.1 Our vision for Accountable Coastal Care

Our ambition is to take our *good* care and make it *excellent,* working together as partners to improve the health and wellbeing of the population, to improve outcomes for individuals and to deliver better value for money. **Organisational boundaries will no longer be barriers to our patients or to our staff.** We will improve the way we deliver care (introducing a new model of care, described in chapter four of this document) and improve the way organisations work together (establishing an Accountable Care Organisation, described in chapter six, through which we will deliver the new model of care).

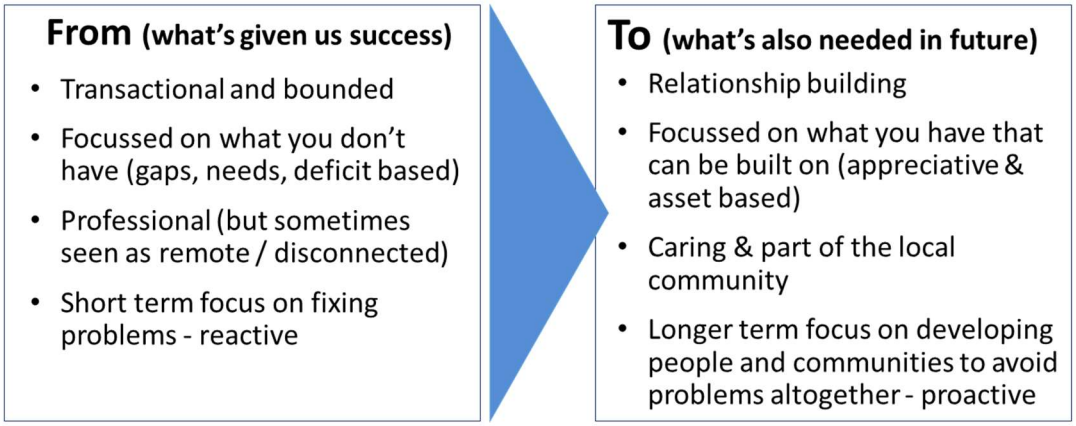
Our vision for Accountable Care in Coastal West Sussex

- Promoting physical, mental & social well-being; by preventing ill health, intervening early and supporting people to better manage their care - moving from reactive to proactive
- Organising and delivering care in partnership with local communities and other agencies
- Breaking down organisational boundaries to create a system where local health and care partners collaborate to resolve the issues for our population, integrating care pathways to be more effective
- Having a single approach for the whole population whatever their health or care need; generalist or specialist, physical or mental, adult or child
- Aligning around a common purpose, a single set of objectives and one budget

Through our Accountable Care Organisation, partners will take accountability together for health and care for the Coastal West Sussex population.

Our mission is: *To inspire healthier communities together*.

Our approach is summarised in the figure below:



Biggest gap is cultural – changing the fundamental perceptions of staff and public from reliance / dependence to resilience / independence

We believe this will improve outcomes for local people, enable us to manage demand and make the system financially sustainable. We have a coalition of willing partners helping people stay healthy and manage their conditions.

Working more closely together health and social care partners will:

- bring physical, mental health and social care much closer together for the benefit of patients – at the moment these services are delivered by different organisations which can make it hard and confusing for patients.
- help NHS and social care staff work better together, across organisational boundaries, so that they are best placed to do what they come to work for: to provide accessible, high quality care to patients.

3.2 The impact we wish to have for our population

Through the delivery of our vision, Coastal Care expects to have four key impacts for the population of Coastal West Sussex:

1. Improved **health and wellbeing** of the Coastal population
2. Improved **quality of the care** we provide for the Coastal population
3. Improved **productivity & efficiency**; creating a financially resilient and sustainable system
4. Improved ability to **recruit and retain** a skilled and motivated workforce

A single set of system objectives and supporting metrics will be developed to drive our shared delivery, covering:

Desired Impact	Example metrics (to be developed further)
1. Improved health and wellbeing	▪ Safer communities ▪ Reduced preventable mortality ▪ Reduced Avoidable Harm ▪ Improved empowerment of local people ▪ Maternal Smoking at delivery ▪ Cancer 1-year survival rates ▪ On plan for share of 3,000 therapists in
2. Improved care quality	▪ Improved positive feedback from p ▪ Emergency bed-days per 1,000 ▪ Emergency admissions ▪ Percentage of patients … rged from A&E within 4 hours ▪ Patients waiting 18 w… to hospital treatment ▪ GP availability and acce…
3. Improved productivity and efficiency	▪ Distance from control tot… plan ▪ Agency spend
4. Improved ability to recruit and retain staff	▪ Reduced vacancy rates ▪ Staff satisfaction scores

To be developed further to include a range of metrics that's reflect the whole system – currently includes some locally suggested and some STP level metrics

4 The new care model

This chapter describes the new Coastal Care Model through which we will meet the needs of the population. It also introduces eight Local Community Networks (LCNs) and their role as the building blocks of the new model.

4.1 Introduction to the new care model

Chapter two of this plan summarises the case for change across Coastal West Sussex. The way that services and care are currently provided is not sustainable and will not be able to respond to the challenges faced across the system. Responding to this, the way services are delivered in Coastal West Sussex will be improved. The new Coastal Care Model needs to:

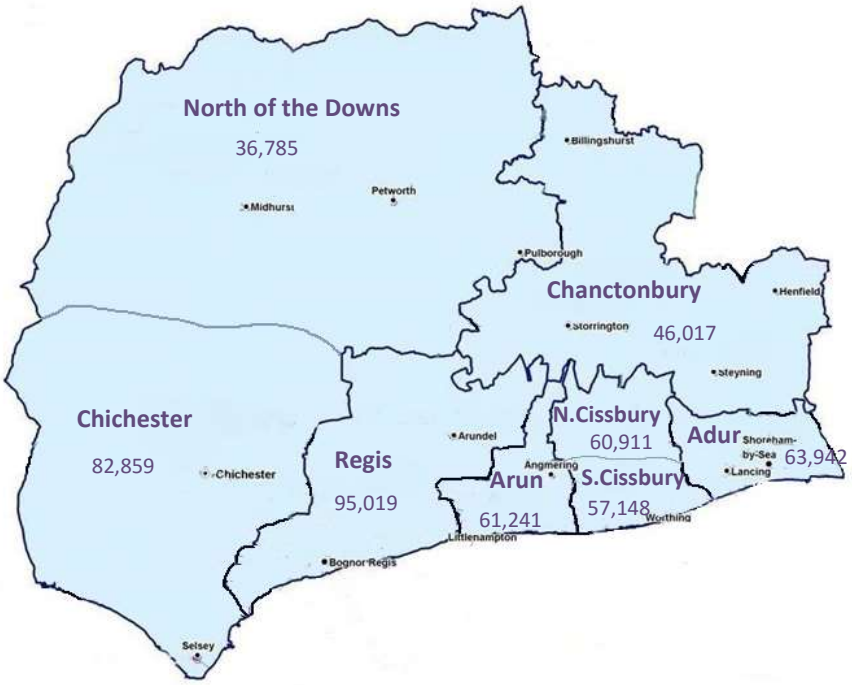
- Care for one of the oldest and rapidly ageing populations in England and moderate increases in demand from chronic diseases, multiple conditions and frailty
- Work with children, young people and families to give the adults of tomorrow the best possible start
- Provide care that is a lot more holistic and that supports people to improve their resilience, self-management and prevent illness and deterioration
- Respond to the very different local mix of needs across the communities that make up Coastal Care.
- Respond to a growing capacity gap in General Practice that cannot be resolved by recruitment alone
- Respond to a shrinking market of domiciliary care provision at a time when the needs of people being supported in their homes is increasing
- Reduce unnecessary emergency admissions to hospital and attendances at A&E
- Reduce variation in the effectiveness and quality of care at each stage of the pathway across the system

This chapter introduces eight **Local Community Networks (LCNs)** and their role in as the building blocks of the new model. It describes the new **Coastal Care Model** and how it organises and provides care for the population for different levels of need, in an integrated and proactive way that responds to the systems challenges. It gives further detail on the role of Local Community Networks in the delivery of the new model and the **LCN Development Plan** that will support this. It ends with a description of the **Care Model Priorities** for 2017/18.

4.2 Local Community Networks

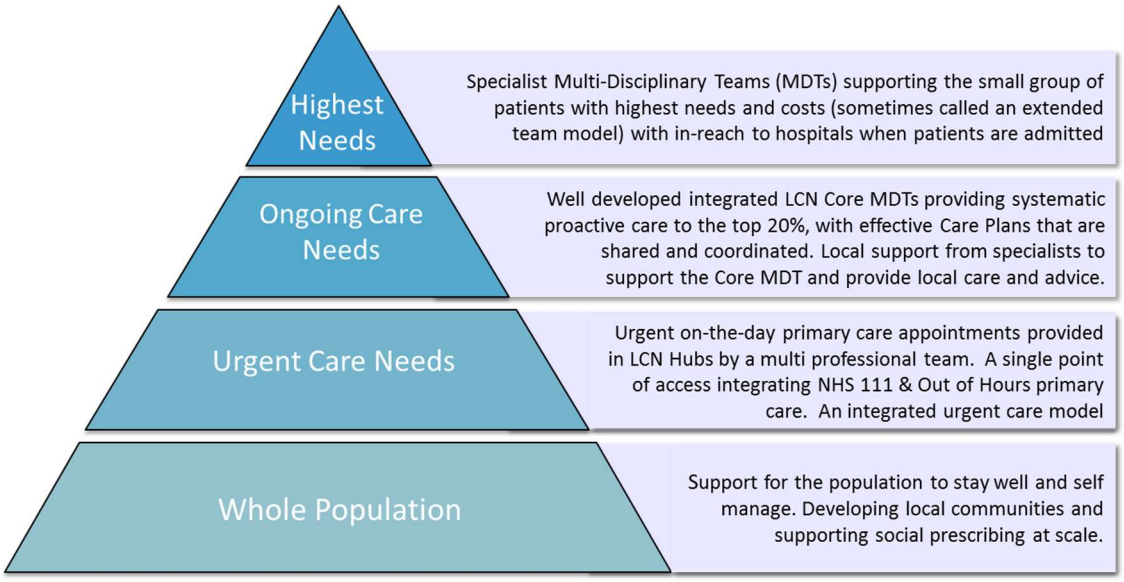
Eight Local Community Networks (LCNs) form the building blocks of the Coastal Care Model. Each LCN will take a place-based approach to integrating care and services around the needs of its local communities. Their objective is to break down organisational and professional boundaries to create system where general practices, local health and care partners, third sector organisations and the community, work together with a common purpose. Their priorities will be promoting physical, mental and social wellbeing, by preventing ill-health, earlier intervention early and by supporting people to manage their care.

Figure x: Eight Local Community Networks



4.3 The Coastal Care Model

The Coastal Care Model has been designed to respond to different levels of need in the population in an integrated, well planned and holistic way, focusing on the needs and circumstances of each person.



Taking each of the four levels of population need in turn:

i. Whole population

As described in chapter two, Coastal West Sussex has one of the oldest populations in the country with 25% aged over 65. With age comes frailty and illness. There are also wide inequalities between the communities that make up Coastal Care with some local neighbourhoods having a life expectancy over 10 years shorter than their neighbours.

Around 80% of deaths are from major disease, such as cancer that are attributable to lifestyle risk factors such as smoking, excess alcohol or poor diet.

Coastal Care will therefore need to have an outstanding capability to moderate increases in demand including through self care, better prevention and early intervention. To be complete, this approach will include working with children and families. An *Asset Based*[2] approach will be taken - working with the communities that make up Coastal Care to understand, use and enhance the assets that are already there:

- Identifying and making visible the health-enhancing assets in a community
- Seeing people and communities as the co-producers of health and well-being, rather than the recipients of services
- Promoting community networks, relationships and friendships that can provide caring, mutual help and empowerment
- Valuing what works well in an area, and identifying what has the potential to improve health and well-being
- Supporting individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources
- Empowering communities to control their futures and create tangible resources such as services, funds and buildings.

The population and needs analysis described above as part of the LCN Development Programme is an important first step to understanding and working with the assets in each community. It will also give important information on the lifestyle factors that need to be prioritised in a *Prevention Programme* for each LCN, be it smoking, diet, exercise, alcohol, emotional wellbeing and loneliness – or combinations of these.

Social Prescribing will be a key way of supporting individuals and communities with the many non-clinical ways to promote and maintain people's health, wellbeing, independence and resilience. It is estimated that 20%[3] of patients consult their GP for what is primarily a social problem. Social Prescribing responds to this by signposting and supporting people to access their local assets, such as voluntary groups, housing and benefit advice, children's centre, time bank and so on. When done well and at scale Social Prescribing becomes virtuous, the people it helps today become the people who help others tomorrow.

Further developing relationships and partnership working with the third sector will be crucial to develop and deliver the new model of care.

ii. Urgent Care Needs

A key priority is the redesign of **urgent 'on the day' primary care appointments**. An audit of primary care appointments found that demand for an 'on the day' slot was almost twice the planned capacity. It has become increasingly difficult to recruit GP's to cope with increasing demand and a large proportion of practice nurses are due to retire in the next five years. An extensive public and patient survey found a clear sense that people prioritise seeing their own

[2] **An asset** is any factor or resource that enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses.

[3] Report of the Annual Social Prescribing Network Conference. 20 January 2016.

doctor for long term conditions, but are happier to see a different doctor if it is faster for immediate problems.

To respond to this challenge, each LCN will redesign how they provide 'on the day' primary care. Appointments will be triaged at LCN level and clinical resources will be pooled to see these patients in an LCN Hub. A Multi-Disciplinary Team approach will be taken, with patients triaged to see a doctor, nurse, therapist or pharmacist each able to access the patients care record. Where appropriate, alternatives to face to face appointments will be offered. As LCNs develop their hubs and local infrastructure it will be possible to increase the range of diagnostic tests provided locally to support providing most urgent care locally.

As well as responding to the pressure and scarcity of GP time in the current model, this redesign of urgent care also aims to free-up and create time for GPs to spend providing ongoing care to their patients. This is described in the next section. It is hoped that improved ongoing care will in turn reduce the occasions when patients have urgent and unplanned needs – a virtuous circle.

The new care model will also create **integrated 24/7 urgent care** for the whole system. This will cover all urgent care needs – from easily accessed advice, through to major trauma. Coastal Care provides an opportunity to create a coherent and streamlined system that has an effective single point of access which is clear to the public and directs people to the most appropriate urgent care service for their need. The new system will break down barriers between urgent physical and mental health and ensure that these services and their workforce are able to support people as close to home as possible. When patients need the care of the acute hospitals and A&E departments they will be supported to return home once they are medically fit.

iii. Ongoing care needs

We know that about one quarter of the population of Coastal Care have a long-term condition and that as the population gets older this will increase, and that more people will have multiple conditions and more complex treatment plans and medications. Our Care Model works to provide proactive care and support as people's needs increase, with the aim of delaying and avoiding the progression of, or number of, conditions that individuals live with.

The key to providing proactive care is the integration of primary and community based care in each LCN to form effective Core Multi-Disciplinary Teams (MDTs) operating from local Hubs. Patients requiring proactive care and support from these MDTs will be systematically identified using risk stratification and case finding tools. MDTs will resourced and developed to work as high performing teams, with time and technology to coordinate and share the care given to patients. Each MDT will develop effective Care Plans for their patients and by involving patients and their carers in this will ensure they understand them and know what to do. Care Plans will be electronic and easily shared within the MDT, with patients and across the system with other providers when necessary (e.g. ambulance and A&E). New Coordinator/ Navigator roles will be developed in MDTs to be a point of contact for patients and carers and to ensure that their Care Plan is a live and relevant document. Working this way will reduce unnecessary duplication for patients and staff.

Specialists have a key role in supporting and advising the Core MDTs in the management of patients locally. This will be done in a number of ways. Specialists such as Geriatricians could join the Core MDT to develop and deliver the Care Plans for frail older patients. Specialists such as Cardiologists or Respiratory consultants could provide a Specialist MDT at the LCN Hub. More of the services currently provided at the two acute hospitals will be provided locally and in a more integrated way with primary care and Core MDTs.

There is a desire to redesign the relationship between GP's and secondary care Consultants to one where it is easy to get advice in real time using the telephone or internet. New integrated pathways will be developed in partnership long term conditions and specialities where there is potential to provide improved care earlier in the pathway and closer to home in LCNs.

iv. Highest needs

In each LCN there are a small number of patients whose needs are greatest and are receiving high levels of care and support. They are likely to have multiple long-term conditions or be diagnosed with frailty and could be supported to live at home or have moved into a Care Home. In the current system they are the group of patients that are frequently brought in an emergency to the acute hospital.

Our new care model will provide integrated proactive care for these patients, with Care Plans that aim to improve their care and support at home and reduce the need for them to be in an acute hospital. The MDTs supporting these patients and their carers require greater expert advice than is likely to be available in the Core MDTs. Each LCN will develop Specialist MDTs that provide the expertise required to support their patients with the highest needs. This could include MDTs led by expert generalists (such as a geriatrician supporting the most frail patients) or specialists (such as a cardiologist leading the care for patients with heart failure). Another form that a Specialist MDT could take would be a team dedicated to caring for the highest need patients who are housebound. The aim will be to reinvent traditional clinical roles and develop an approach that blends the generalist skill set of a GP with expertise in a number of long term conditions.

While the aim is to support these patients to stay out of the acute hospitals, it is recognised that there will still be times when they need to be admitted. In the new care model the links with the LCN MDT are maintained when patients are in hospital, with the potential for members of the MDT to plan their treatment and discharge.

With the age profile of Coastal Care, there is a clinical and professional consensus that an early priority needs to be given to the care for frail older people.

4.4 Developing the Local Community Networks

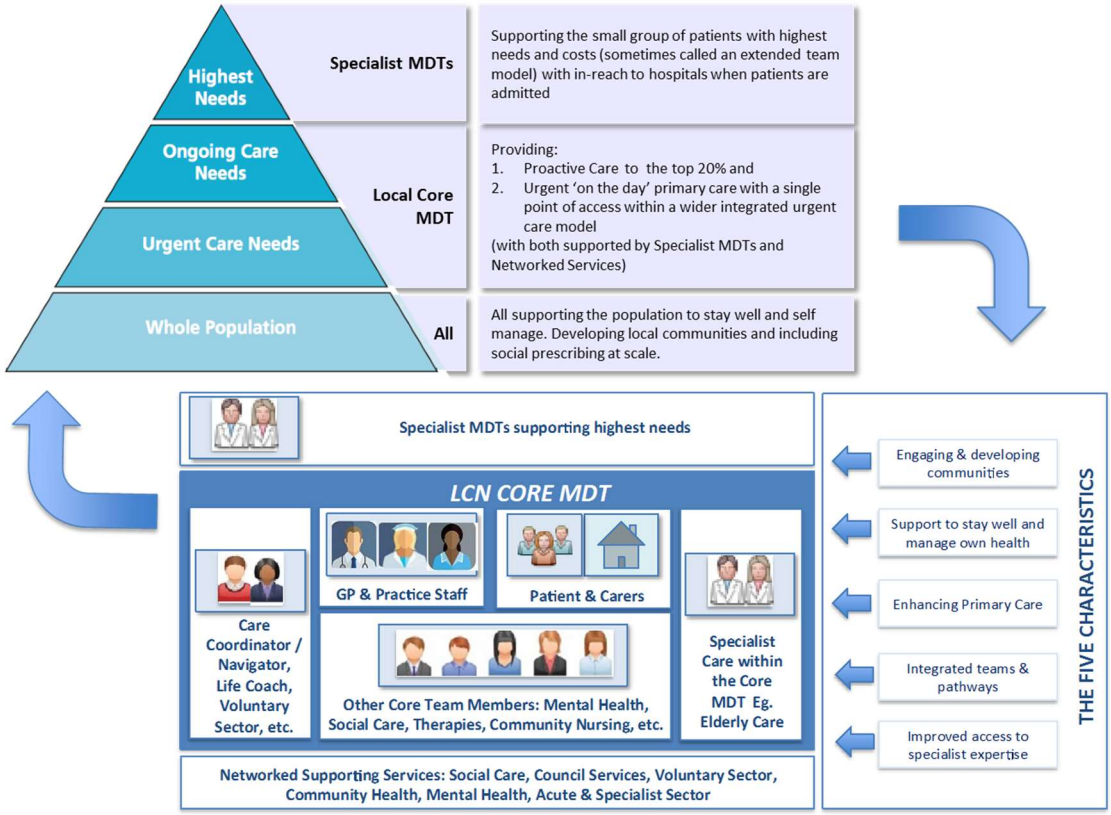
The eight Local Community Networks are the fundamental building blocks of the new model of care. Creating the LCNs is not about re-badging what we are already doing – it is about creating and resourcing eight networks that become the building blocks of our new care model and are able to drive and account for its delivery. Each will require new partnerships in a local area, between NHS services, and with partners such as the third sector. The new model of care involves staff working flexibly in new ways and outside of 'traditional areas'; our workforce plan is therefore crucial to the successful implementation of the new model and is described later in this plan.

LCN Hubs

Although each LCN is different, there is an expectation that each will develop their version of an LCN Hub that will provide the practical and operational focus of delivering much of the Care Model. The Hub is where redesigned urgent 'on the day' appointments will be triaged and seen. The Hub is where much or most of the Core MDT and Specialist MDT activity will take place or be coordinated from. In their design, Hubs will need to make best use of information and digital technology. In larger LCNs there may be more than one Hub. The priority now is to design them LCN by LCN.

LCN Model

The following diagram describes how the population levels in the Coastal Care Model are supported locally in LCNs by their Core and Specialist MDTs.



Each LCN will be resourced and supported to deliver five characteristics identified as being the priorities that deliver the Coastal Care Model:

Engaging and developing communities	Building an understanding of & relationship with their local communities. Working in partnership with the County, District and Borough Councils, third sector and community leaders to map and understand their assets and how communities can be supported and developed.
Supporting people to stay well and manage their own health.	Working with Public Health to analyse need in their communities and using this to inform local priorities for prevention activities as part of a Coastal wide programme. Implementing the Social Prescribing in line with the Coastal Care agree approach.
Enhancing primary care.	Redesigning urgent 'on the day' appointments in LCN Hubs to improve access and respond to staff pressures. Develop a medium term primary care workforce model and implement new roles that deliver the new care model.

Integrated teams and pathways	Developing effective Core MDTs that proactively identify patients, develop good Care Plans and coordinate their delivery. Working across Coastal Care to developing new pathways for long term conditions that provide improved care earlier in the pathway and more care within the LCN.
Improved access to specialist expertise.	Developing specialist MDTs that support the patients with highest needs. Redesigning the relationship between GP's and secondary care Consultants to one where it is easy to get advice in real time using the telephone or internet.

Development plan

An LCN development plan is in preparation and will include the following:

- **LCN population needs analysis and community mapping**. Each LCN will be responsible for understanding their local population and communities so they can prioritise improvements and work and engage with them in their delivery. Mapping is an essential part of this and will be supported by West Sussex County Council and the District and Borough Councils.
- **Leadership and team development**. Supporting the individuals and teams that will lead and deliver the new care model in each LCN is essential. We want to build new and sustainable structures, processes and culture across the teams and empower them to shape and improve the services they provide. As LCNs form, management resource from other parts of the system will be identified to support each of them.
- **Patient and community engagement**. Working in real partnership with patients and communities is central to the new care model and the plan will ensure that each LCN has the capability and capacity to do this well.
- **Hub development plan**. Supporting each LCN to review their options for developing their Hub(s)
- **LCN integrated performance reports**. At the moment, performance is reported by organisation and for our new model we will need to collectively understand performance by LCN. This should include the local metrics and feedback that the LCNs need to see regularly to understand the progress and improvements they are making.

4.5 Priorities for 2017/18

- Finalise the geography for each LCN and design and implement the development plan that brings them on-line in 2017/18.
- Undertake the detailed community asset mapping of at least two of the first LCNs. Use the learning from these to inform the plan to complete this across all eight.
- Undertake the health needs analysis for all eight LCNs, to inform priorities.
- Evaluate the current Social Prescribing pilots and recommend a model to be implemented at scale across Coastal Care.
- Review the options and agree a plan for developing Hub(s) in each LCN.
- Implement the redesign of urgent 'on the day' primary care appointments.
- Develop plans for supporting frail elderly patients within the new model.
- Research best practice in Case Finding, Care Planning and Care Coordination and develop plans for their systematic deployment.
- Agree three integrated pathways to be designed and implemented across Coastal Care.

5 The key enablers to deliver the new model of care

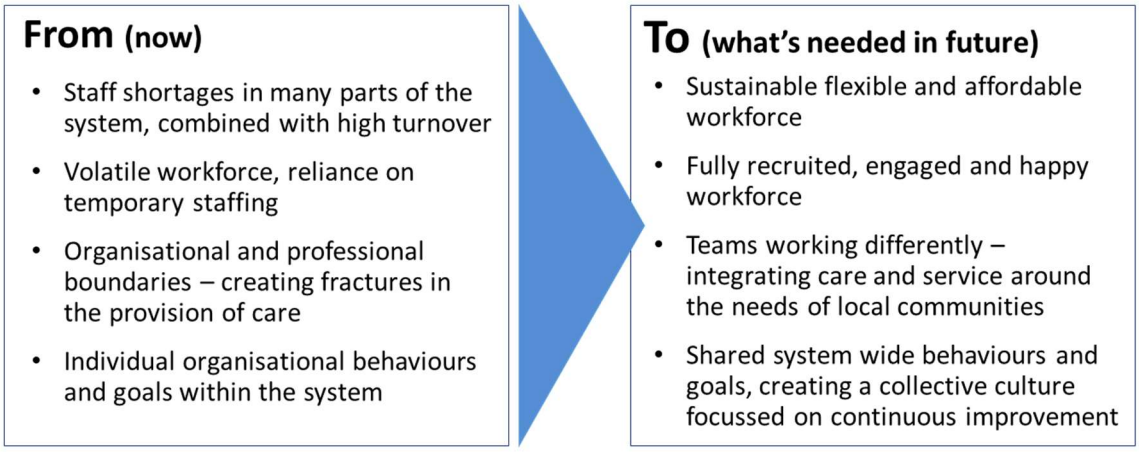
This chapter of the plan describes three key enablers to the delivery of the new model of care. It summarises our workforce development plan, our plans to establish a Shared Care Record and other digital technologies, and our approach to communications and engagement with staff and with local people.

5.1 Workforce Development

People will be at the heart of the system that we are building - so refining our workforce plans to ensure a sustainable workforce aligned to our vision is a priority. Equally, developing a framework for our system in which strong leadership creates a culture where our people can thrive is key: supporting and enabling people to work together to continually improve and develop services.

The cultural change required to support service changes will be associated with a blurring of organisational and professional boundaries. Local leaders will need to drive through changes in current practice as well as steering the strategic workforce planning agenda that delivers the workforce of the future.

A workforce and Organisational Development Strategy for Coastal Care is being developed through a Coastal Care Workforce Steering Group. Our approach is summarised below:



Our 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 are:

- Continuing to work together to identify and resolve **immediate workforce pressures** and opportunities to stabilise the current system. This currently includes reducing the use (and cost of) temporary staffing, and collective recruitment solutions.
- Supporting the vision for Coastal Care 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**, in which will describe how we will develop both a sustainable workforce for the future, and our Accountable Care Organisation. The Strategy 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, in a culture that is focused on continuous improvement and puts patients first and foremost.

- Developing a **framework for change** that supports the development of a successful organisational change. Staff engagement is key to the success of organisational change, and we will work together with the communications and engagement work stream to truly engage and enthuse our staff.
- Designing a **leadership development** programme that will enable the system leadership needed to deliver real change and to develop people in line with our vision.

5.2 Developing a shared care record and digital technology

As described in chapter four of this plan, technology 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.

The development of a shared care record is an immediate priority and will 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. For example, central Manchester uses a common care plan for 6,000 patients with long term conditions and this plan is reviewed and updated by clinicians across primary care, acute, mental health, social care, community care and other services such as ambulance and the OOH service.
- **Support for clinical alerting and decision support** across care providers. Alerting for example would allow a community nurse to be alerted when one of their patients is admitted into hospital, a GP practice to be notified when a patient has any contact or treatment from other services and relevant people and teams to be notified with social care alerts.
- **Task management, clinical communication and referrals across care communities** so that clinicians can ask for advice or support on-line, cross care community workflow can be introduced and the requests and responses are recorded as part of the patient record.
- **A patient/citizen portal so that people can login once and see their whole care record** with data from across Coastal Care. The ability for patients to contribute to their own care record and to communicate with carers
- **Supporting risk stratification** and other new care model initiatives – the ability to use risk stratification to identify groups of at risk patients is crucial to support Local Community Networks. Using wearables and online data recording to support the monitoring of patients in the community and the use of sophisticated patient clinical dashboards to manage patient and escalate or reduce care levels as appropriate will also support the development of new models of care.
- **Provision of Coastal Care-wide data warehouse and reporting** so that the impact of new models of care can be monitored and managed

Many of the benefits from the IT programme will arise through the service transformation driven by the creation and operation of the new model of care. However specific benefits from the provision of the shared care record will include:

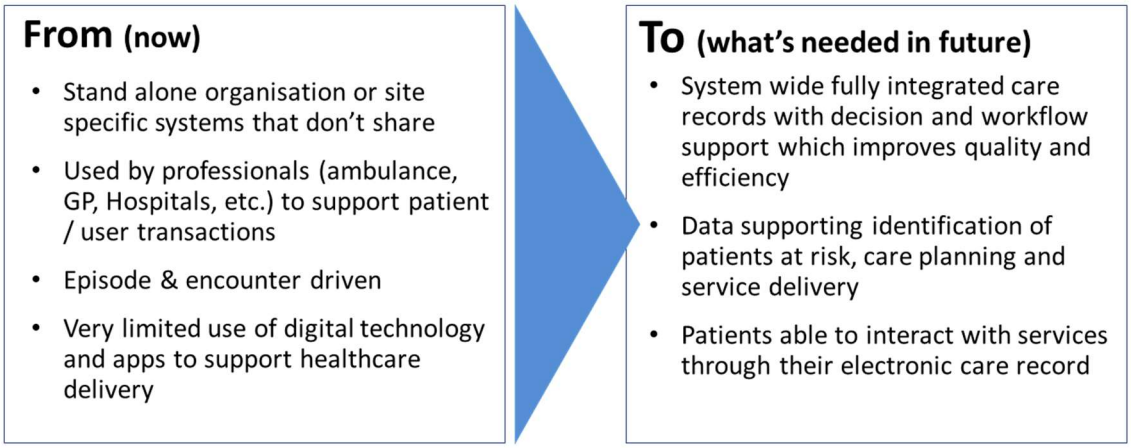
- Flexible digital support for the wider objectives of Coastal Care in line with 5YFV
- Substantial time savings in both in finding information and in staff communication
- Proactive alerting rather than a reliance on clinicians looking for information reduces treatment delays and deterioration of patients
- Faster commencement of appropriate treatment due to the availability of information and faster communication leading to shorter length of stays and a healthier population
- Increased involvement in their own care supports improved population health

The costs of developing the shared care record and digital transformation are estimated to be in the order of £5m.

The indicative timelines for the digital transformation programme are summarised in the table below:

Preparatory activities Nov 16 – March 17	Single care record viewer for staff and citizens 2017/18	Incremental improvement and capability enhancement 2018/19 – 2019/20
▪ Ratification of Specification ▪ Engagement ▪ Procurement ▪ Creation of ACO/STP Digital Governance & IG groups	▪ Deployment of local infrastructure and hardware ▪ First of data sources integrated including GP systems practices, acute PAS and LAB systems, community system & up to 3 additional data sources ▪ Single citizen view implemented	▪ Introduction of care plans for high risk patients ▪ Alerting ▪ Piloting and roll out citizen portal (including integration with patient owned devices) ▪ Rationalisation of Trust systems ▪ Introduction of single ACO analytics & risk stratification

The figure below summarises the shift being introduced through investment in digital technology.



5.3 Coastal care communications and engagement strategy

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 Coastal Care and the new care model. The communications and engagement strategy is underpinned by the following principles: open, timely, relevant communications; planned engagement with staff, patients, carers and communities (public); a clear case for change based on the patient's benefit; and plain English.

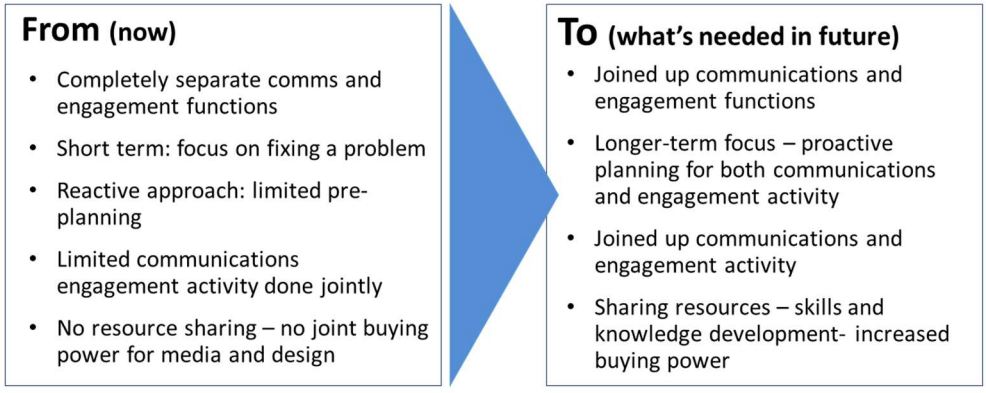
Coastal Care is a journey and we want to ensure staff, patients, carers and communities are with us every step of the way. The communications and engagement strategy will include the following elements:

- leadership of stakeholder and public engagement, public affairs, media and social and online media
- delivery of materials, such as documents stating the benefits of change, consultation documents, website information and presentations
- internal communications with the leaders and staff within all of the partner organisations and relevant politicians and committees, such as HASC
- development of an overarching, multi-channel communications and engagement strategy that meets best practice considerations
- communications and engagement advice on the management of the programme.

The first phase of our strategy (Autumn 2016) is to develop a clear, compelling and credible narrative that will enable us to engage more widely with stakeholders - what is Coastal Care? A programme of independent facilitated focus groups in November 2016 has been commissioned, with key audiences: patients, carers, staff and partner agencies to:

- create an early, important opportunity to begin a wider conversation with stakeholders involved in Coastal Care
- help us test our key messages about the new care model and Local Community Networks
- give us insight on improvements health and social care 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.



6 Accountable Care Organisation Governance Arrangements

This chapter describes our plans to establish an Accountable Care Organisation - the organisational and governance arrangements that are being put in place to enable partners to work together to deliver the new care model, to drive greater productivity and efficiency, and to take accountability together for health and care in Coastal West Sussex.

6.1 The case for developing an Accountable Care Organisation

Chapter two of this plan describes the overwhelming case for change in Coastal West Sussex, the challenges facing the health and care service which require a new approach. Chapter four sets out the new model of care, based around Local Community Networks, which is being introduced to address these challenges, to improve care quality and to close the gap between the available resources and the costs of delivering care.

Introducing those new models of care requires high levels of collaboration between partners, and integrated delivery and a shift of resources from hospital based care to primary and community based care. Organisational boundaries can get in the way of making this happen. There is widespread consensus that the current payment, contracting and organisational arrangements contribute to the fragmentation in the system, and don't support integrated population based care. In current ways of working:

- Regulatory and governance arrangements focus on the success of individual organisations rather than on the success of the whole system, and individual organisational interests tend to 'trump' system interests.
- Individual organisations have different goals and objectives, measure their own success and are assured using different measures, rather than there being a shared goal, and common purpose in a system
- Incentives are not aligned in the system to deliver the common purpose. A range of different payment and contract mechanisms exist, with payments linked to activity rather than outcomes, not aligned to the new models of care, and with risk held in the system in inappropriate places.
- The complexity of having multiple sovereign organisations working to deliver care to individuals, in particular for individuals with complex needs, tends to increase hand-offs and increase service fragmentation. Patients experience disjointed, sub optimal care.

In order to respond to these issues we are introducing a new way for partner organisations to work together to deliver the new model of care – **establishing an Accountable Care Organisation** in Coastal West Sussex.

The intention is that this new approach breaks down the current organisational barriers to create a system where local health and care partners collaborate to resolve the issues for the population, integrating care pathways to be more effective, and reducing bureaucracy and overhead costs.

6.2 Proposed Accountable Care Organisation arrangements

Providers and commissioners of health and care services in Coastal West Sussex have committed to establish an Accountable Care Organisation for Coastal West Sussex.

The Accountable Care Organisation provides a formal and legal structure through which providers and commissioners will take accountability together for health and care in Coastal West Sussex.

The Accountable Care Organisation (ACO) will be developed over the next 18 months, to be in place by April 2018. Once fully operational the ACO will:

- bring together responsibility for local primary, community, mental health and acute NHS care provision for the Coastal West Sussex population into a single organisation. West Sussex County Council will be fully aligned with the ACO.
- be responsible for delivering the new model of care set out in this plan, and for developing and enabling local community networks to flourish.
- hold a single, long term capitation and outcomes based contract with NHS Coastal West Sussex, and be accountable for delivery of a series of population health outcomes for Coastal West Sussex. This contractual arrangement will enable the CCG to evolve into a more strategic commissioning role, and with some functions currently managed within the CCG transferring to the ACO.
- be an NHS body, a legal entity with a lay chair, appointed Chief Executive, executive and non-executive directors.
- be responsible for planning and prioritisation of health and care in Coastal West Sussex.
- will employ staff and hold contracts with other providers.

List based primary care is the foundation of the NHS and ensuring strong, redesigned, local primary and community care is crucial to the successful delivery of the new model of care. Our care model and financial plan is predicated on shifting resources from hospital based care to primary and community based care in Local Community Networks.

It is proposed that individual GMS contracts continue to be held by NHS England, as in the current arrangements. The Accountable Care Organisation, working with GP leaders, will work to develop and commission primary care as part of each Local Community Network.

The establishment of an Accountable Care Organisation will provide common purpose, aligning all partners around a single set of system objectives and outcomes, and around the delivery of the new model of care. It will promote accountability for the whole system and for delivery of the system objectives, and align incentives, striking an appropriate balance between risk and reward for individual organisations.

Working as an Accountable Care Organisation will also support improved decision making, through the involvement of partners from the whole system, and the arrangements will provide the Board with decision making rights to move resources in the system to deliver the new care model and to drive productivity. A key benefit will be to enable better deployment of the workforce across the whole system. The new model will also reduce transaction costs in contracting processes.

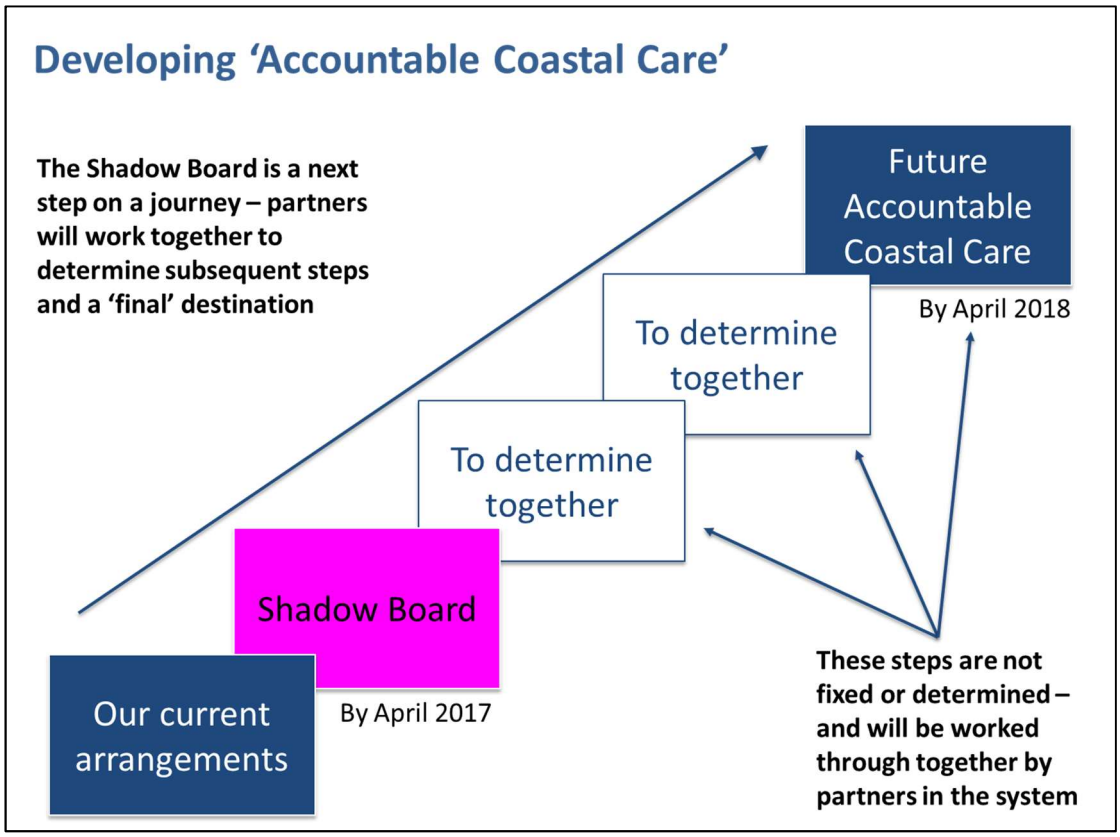
6.3 Transition to the new model: Establishing a Shadow Board

The new arrangements will develop over the next 18 months, in a planned approach, rather than be introduced in a 'big bang.' As a first step, a Shadow Accountable Care Board will be established, by 1 April 2017.

The Shadow Board will:

- Take overall responsibility for delivery of health services for the Coastal West Sussex population. This includes being responsible for financial, quality, and operational performance at system level.
- Take responsibility for delivering year 1 (2017/8) of this Coastal Care Plan with specific emphasis on overseeing the development and implementation of the Local Community Networks and overseeing the delivery of the agreed Coastal West Sussex Financial Recovery Plan.

The shadow Board will also work to determine the governance arrangements and form for the Accountable Care Organisation for implementation from 1 April 2018. The figure below summarises the development path for Coastal Care.

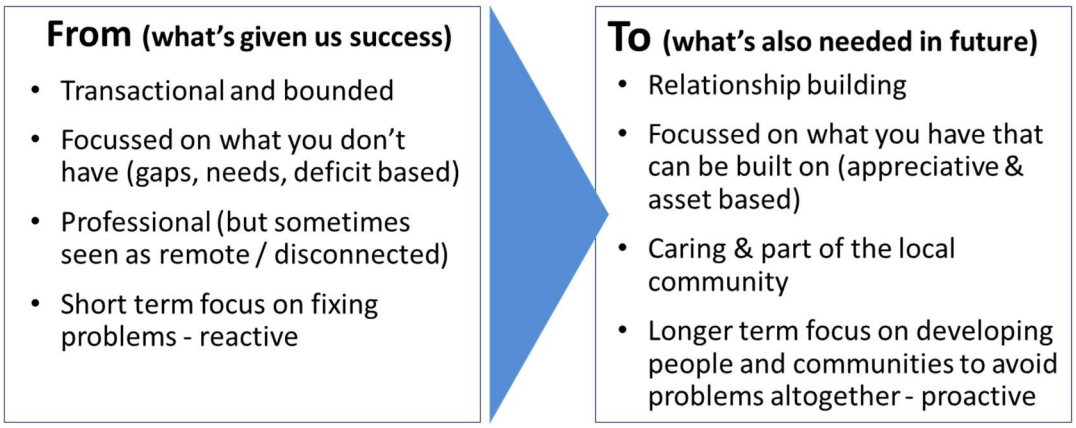


The Shadow Board will comprise of one Non-Executive Director and One Executive Director from each of the System Partners (seven non-executive roles and seven executive roles in total). The Shadow Board will replicate the likely structure of an ACO Board.

7 Development Plan

This chapter describes our Organisational Development Plan for the Coastal Care Accountable Care Organisation and for our Local Community Networks.

As described in section 3.1 of this plan, the introduction of the new model of care and an Accountable Care Organisation for Coastal West Sussex involves a significant and substantial change in culture and requires strong system leadership.



Biggest gap is cultural – changing the fundamental perceptions of staff and public from reliance / dependence to resilience / independence

Our Organisational Development Plan is designed to support leaders at all levels in Coastal West Sussex to engage in, support and lead the delivery of the transformation of services, and the blurring of organisational and professional boundaries. The key components of the plan are summarised in the table below.

Next 3 months	Establishing what leaders will need to be doing differently ▪ Establish key messages to be delivered ▪ Identifying what will be different when the system is operating ▪ Identifying what needs to be different as the system develops through each of its stages ▪ Identifying the practical implications of this on behaviours and use of skills and abilities ▪ Identifying what people will need to believe and value in order for them to feel aligned with and part of the transformation Establishing who the key players are in leading this transformation within and across organisations, the roles/levels, numbers of individuals involved and working patterns/accessibility issues. Establishing the skills that key players will need for the transformation to succeed. Current thoughts are the ability to: ▪ Collaborate ▪ Engender trust ▪ Take responsibility and feel accountable for the project's success ▪ Communicate clearly and with passion ▪ Empower others ▪ Understand the need for compromise and do it willingly for the good of the system Establish current skills levels of those leading/key players in this transformation

	▪ Current levels of trust in the project/process and in the organisations/ leaders involved ▪ Current levels of understanding and enthusiasm for the project's success ▪ Current levels of ownership and empowerment for contributing to the project's success: awareness of what they are responsible for ▪ Current communication processes within and between organisations: effectiveness, mechanics, reliability, consistency ▪ Identify expertise within and across the organisations and how best to engage and coordinate this to support the project ▪ Current responses to change/transition and best practice to navigate that Undertaking a GAP analysis using the information from the above two activities to identify future OD and LD activity Establishing a reliable programme of system wide communication methods (online/printed/meetings etc)
Jan-March 2017	System wide briefings of all leaders/key players outlining ▪ What lies ahead and why it is important: engaging them at a beliefs and values level (system mission and identity statements: why this is important; identifying the benefit to their client group; engaging them as key players in the system; enabling them to put the system first and their organisation second for the benefit of their client group) ▪ Their role within it ▪ What is required of them, including their responsibility for communicating across their organisations ▪ What support is available ▪ Immediate expectations in terms of message delivery etc to those they are in contact with ▪ Gathering their thoughts and ideas on the best way forward to weave in to OD plan ▪ Gathering their insights in to their skills and skill gaps to weave in to the LD provision Delivering "leading through change" workshops to all leaders. Delivering "understanding the impact of change" workshops to as many beyond leadership roles across the system as possible. Focussed development activity to meet the needs identified by the GAP analysis for particular groups/for all. Regular meetings/bulletins/updates/webinars or however we are delivering the transformation messages
April '17 onwards	Regular cross organisational workshops for key players/leadership groups ▪ To provide discussion forums ▪ To provide development input ▪ To ensure clear communication and updates ▪ To tackle immediate/immanent issues as they arise Regular meetings/bulletins/updates/webinars or however we are delivering the transformation messages
April 18	Regular cross organisational workshops for key players/leadership groups ▪ To provide discussion forums ▪ To provide development input ▪ To ensure clear communication and updates ▪ To tackle immediate/immanent issues as they arise Regular meetings/bulletins/updates/webinars or however we are delivering the transformation messages

8 Financial Plan

This chapter describes the financial challenge facing health and care services in Coastal West Sussex, and models the initial assumptions that have been made regarding the impact of introducing a new model of care, productivity and efficiency savings, and an Accountable Care Organisation.

8.1 Activity and financial modelling

A whole system activity and financial model has been developed to support the STP and this Coastal Care Plan. The model enables the system to understand the system wide challenge, and model the impact of new models of care and other interventions planned to address it. The model:

- Provides a taxpayer view of future costs in comparison with available funding for health and social care
- Provides a commissioner view of the impact of planned interventions on the quantity of activity needed to be commissioned and the costs to commissioners of this activity
- Gives a provider view of the impact on the quantity of activity each main provider is expected to deliver and the resulting impact on each provider's income and expenditure.
- Demonstrates the impact on social care

Two scenarios have been modelled:

- A "do nothing" baseline scenario which applies assumptions of inflation and activity growth to the current position, assuming no new models of care or other interventions take place.
- A "do something" scenario, based on a range of assumptions concerning efficiencies and the potential costs and benefits of new models of care.

8.2 Scope

A number of organisations provide services for the population of Coastal West Sussex. The finance and activity model assumes the following share of partner organisations activity:

- 100% of Coastal West Sussex CCG commissioned services
- 100% of Specialised Services commissioned by NHS England on behalf of the local population
- 100% of Western Sussex Hospital FT
- 44% of Sussex Community FT
- 28.5% of Sussex Partnership FT
- 26% of South East Coast Ambulance
- 58% of adult and children's social care and public health commissioned by West Sussex County Council

The starting point for the model is 2016/17 plans, adjusted for Sustainability and Transformation Fund income and underlying deficits of £13.9m for commissioners and £5.1m for providers. The model covers the 5 years from 2016/17 to 2020/21.

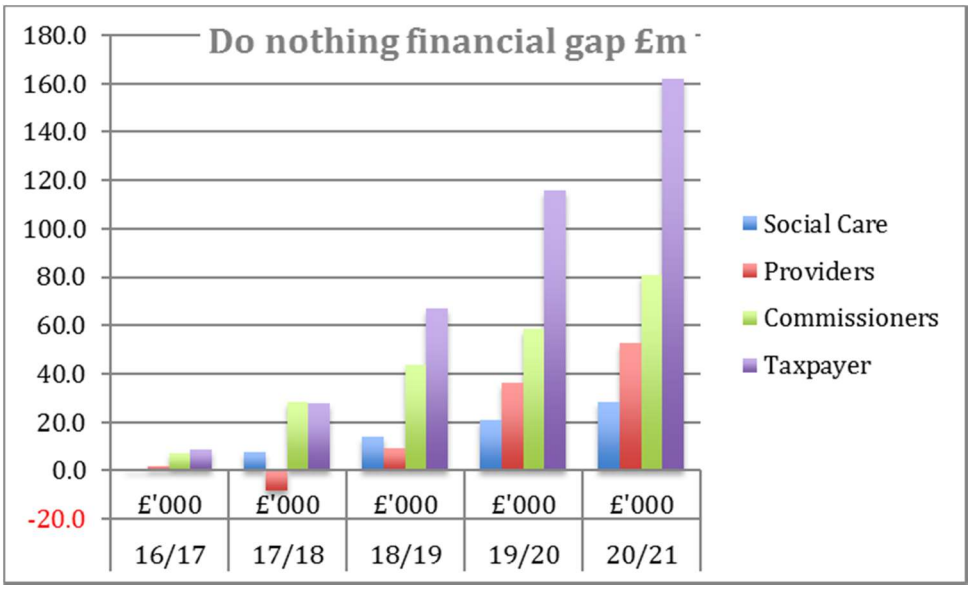
8.3 Baseline scenario - "do nothing"

The combined health and social care resources available for the local population totalled approximately £1,267m in 2016/17, comprising c£963m NHS funding and c£304m of social care for adults and children. The total NHS and social care resources available are expected to rise by c£160m to £1,428m by 2020/21.

However, the costs of delivering services in the current models will continue to rise, as a result of increased demand and due to price inflation. In the do nothing scenario, the gap between available resources and costs is therefore forecast to be £28m in 2017/18 rising to £162m in year by 2020/21. The split between partner organisations is shown below.

Do Nothing Gap	16/17 £m	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Commissioners					
CCG	-7.0	-24.4	-35.9	-47.0	-63.8
NHSE	0.0	-4.0	-7.8	-11.6	-17.2
Sub-total	**-7.0**	**-28.4**	**-43.7**	**-58.6**	**-81.0**
Providers					
WSHT	-2.7	8.1	-5.1	-27.9	-40.5
SCFT	1.0	0.6	-1.7	-3.9	-5.9
SPFT	0.2	-0.0	-1.3	-2.8	-4.1
SECamb	-0.3	-0.5	-1.0	-1.5	-2.0
Sub-total	**-1.9**	**8.1**	**-9.1**	**-36.1**	**-52.6**
Total NHS gap	**-8.8**	**-20.3**	**-52.8**	**-94.7**	**-133.6**
Social Care	**0.0**	**-7.7**	**-14.2**	**-21.0**	**-28.5**
Total taxpayer gap	**-8.8**	**-27.9**	**-67.0**	**-115.7**	**-162.2**

Shown graphically across the planning timeframe we can see the relative impact on commissioners, providers, and social care, and the bottom line, or taxpayer view.



8.4 Assumptions

In calculating the baseline position, the following assumptions have been made:

- Activity has been valued at national tariff rates where applicable
- Income and costs have been updated for nationally mandated inflation and tariff efficiency rates.
- STF has been treated as a non recurrent income stream in 2017/18 and 2018/19
- Activity growth has been applied to the 16/17 baseline, based on local demographic forecasts derived from ONS data, uplifted by a local estimate for growth of 2%. Although this combined rate is around 0.7% higher than the national planning assumptions it is considered realistic when compared with actual recent growth rates
- Growth rates have been applied equally across all points of delivery.

Activity growth assumptions- demographic and non demographic

Age band	17/18	18/19	19/20	20/21
0-19	2.58%	2.69%	2.84%	2.93%
20-64	2.51%	2.46%	2.38%	2.30%
65-84	3.83%	3.69%	3.63%	3.69%
85+	3.64%	4.20%	4.71%	4.80%
Specialised Services	7.50%	7.00%	7.00%	7.60%

Note: Specialised Services growth assumptions are in line with STP guidance and reflect higher historical levels of growth

- Where changes occur to baseline activity, whether through growth or the impact of changes to models of care, acute provider income has been calculated at 100% of tariff, with a corresponding marginal cost adjustment of 75%. This provides an inbuilt productivity of 25% within providers, in addition to the 2% CIP.
- The baseline also assumes an investment in national strategic priorities, matching increases within the CCG's allocation. A table showing the impact of this is included in the section on investment below.

The do nothing scenario clearly represents an unsustainable position for the local system. As well as generating a significant financial deficit it would put achievement of national priorities and constitutional standards at risk, put additional strain upon the already stretched workforce position and place significant demands on the physical capacity of local services.

A key example of this is the impact on acute beds that the increased activity represents. From a 2016/17 baseline, with an assumed occupancy of 90%, this would represent a bed increase of 119 to meet the demand increase represented in this scenario.

8.5 Closing the Gap

While cost inflation could be met by increases in commissioner allocations, there is no expectation that additional financial resources will meet potential increases in demand. It is necessary therefore to meet tomorrow's level of demand within today's level of resource.

Two key imperatives have been explored to achieve this:

- the need to increase efficiency
- the need to reduce demand

The plans emerging do so in an environment of increasing collaboration and reducing fragmentation as the Coastal Care system creates an Accountable Care Organisation. While this will enable the development of new, more integrated models of care to help reduce demand, the potential to move from a reactive to a more proactive model of care and the closer working of partner organisations, will also contribute to efficiency through the opportunity to streamline and reduce duplication and waste.

Key features of the Coastal Care financial plan are as follows:

- The provider productivity CIPs have been set at no more than 2% at this stage. These are assumed to be efficiencies driven within each organisation which will not be predicated on system-wide transformational change but will require internal productivity improvements to be realised. These will largely delivered through efficiencies expected through the Carter review.
- GP prescribing QIPP schemes will mitigate the expected 5% price increase by 2%, leading to a net increase of 3%, through a combination of downward pressure on prices and support to prescribing practice in order to increase cost effectiveness. The level of detail on GP prescribing is very granular and the CCG is entering into a Quality contract with the GPs to encourage clinically and cost effective prescribing. To support this the CCG has a well resourced Medicines Management team which can identify the areas of opportunity and work closely with the prescribers.
- Social services cost efficiency of £4m is planned recurrently from 2017/18. It is anticipated that there will be further contributions from West Sussex County Council towards closing the gap. The council is not yet able to confirm a plan, since this could be influenced by a variety of presently unknown factors, such as County Council elections in May 2017, the local government finance settlement and the need for greater clarity about the additional funding for social care planned to be made available via the Better Care Fund from 2018/19. The County Council will also be aiming to make efficiencies as well as having the option to raise a 2% precept for social care.
- The Coastal Care Model described in earlier sections of this document has been designed to provide the care for the whole population and is organised to respond to different levels of need in a well-planned and holistic way, focusing on the needs and circumstances of each person. Implementation of the model will be supported by the Accountable Care Organisation, introducing a new approach which breaks down the current organisational barriers to create a system where local health and care partners collaborate to resolve the issues for the population, integrating care pathways to be more effective. This will have the effect of reducing dependence and increasing independence within the population,

thus reducing overall levels of demand, and ensuring that appropriate, easy to access care is there as people's needs escalate, avoiding the added cost of unnecessary crisis for people and their carers.

While plans are not sufficiently advanced to enable detailed modelling it is estimated that 50% of the anticipated growth modelled in the do-nothing scenario will be mitigated, starting with a half-year effect in 2017/18.

8.6 Investments

The 'do something' scenario includes two significant investments:

- 50% of the savings from activity growth mitigation has been badged to create an investment fund to meet the workforce, infrastructure, and pump-priming of service changes which will be needed to implement the new models of care.
- Investment in National Priorities as shown in the table below. These sums have been calculated from national investment targets, calculated on a per capita basis. As shown at the bottom of the table the sums included in CCG allocations have been included in the do nothing scenario, with the additional investment included in the 'do something' scenario. In addition to the revenue investments above, there will also be a requirement for some capital expenditure. These will focus on the development of integrated care team hubs to support the delivery of new models of care as well as significant investments in IT infrastructure as an enabler to delivering integrated care.

Investment £m	2017/18	2018/19	2019/20	2020/21
Seven Day Services Roll Out to 2019/20	0.0	0.0	1.2	2.4
General Practice Forward View/Extended GP Access	3.0	3.0	3.5	4.6
CAMHS capacity and Implementing Access and Wait Targets for ED Services	1.6	1.8	2.0	2.2
Implementing the recommendations of the mental health taskforce	0.9	3.2	5.1	7.0
Cancer Taskforce Strategy	1.6	1.9	2.2	2.5
National Maternity Review	1.0	1.5	2.0	2.5
Investment in prevention, tackling childhood obesity, & Improving diabetes diagnosis and care	0.5	0.5	0.5	0.5
Total investment	**8.5**	**12.0**	**16.7**	**21.8**
Less amount in allocations and the do nothing	1.1	1.5	1.7	12.3
Additional investment - do something	**7.4**	**10.5**	**15.0**	**9.4**

The total impact of all of these changes to close the gap is shown below

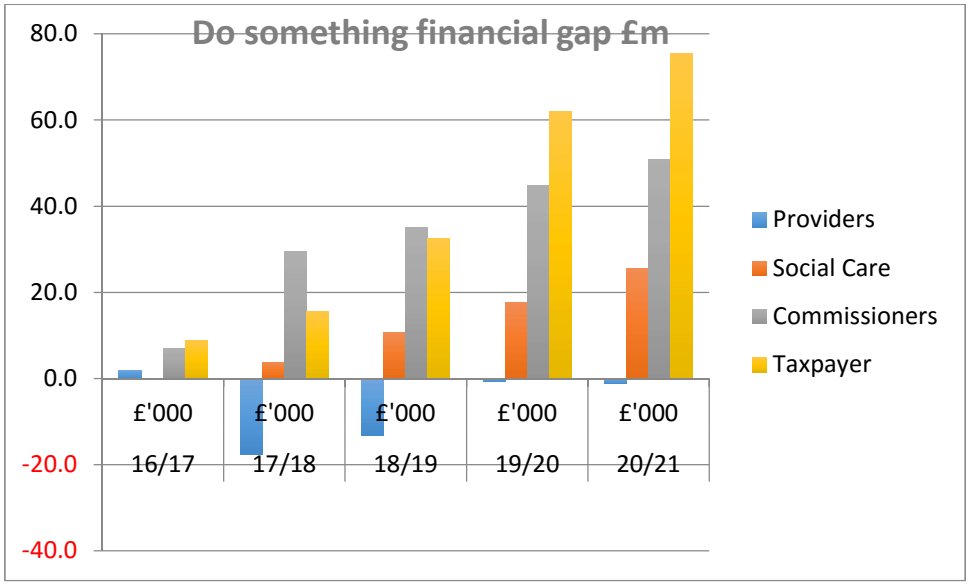
Closing the Gap	17/18	18/19	19/20	20/21
Efficiencies	£m	£m	£m	£m
Provider Cost Improvements	12.8	27.2	43.1	61.1
QIPP GP Prescribing	1.9	4.1	6.5	9.2
Social Care Efficiencies	4.0	4.0	4.0	4.0
Activity Avoidance				
New Models of Care mitigate growth	1.7	18.9	30.4	43.8
Investments				
Cost pressure from Priority Investments	-7.4	-10.5	-15.0	-9.4
50% of growth mitigation re-invested	-0.9	-9.5	-15.2	-21.9
Total all initiatives	**12.2**	**34.3**	**53.8**	**86.8**

8.7 Business case scenario - "do something"

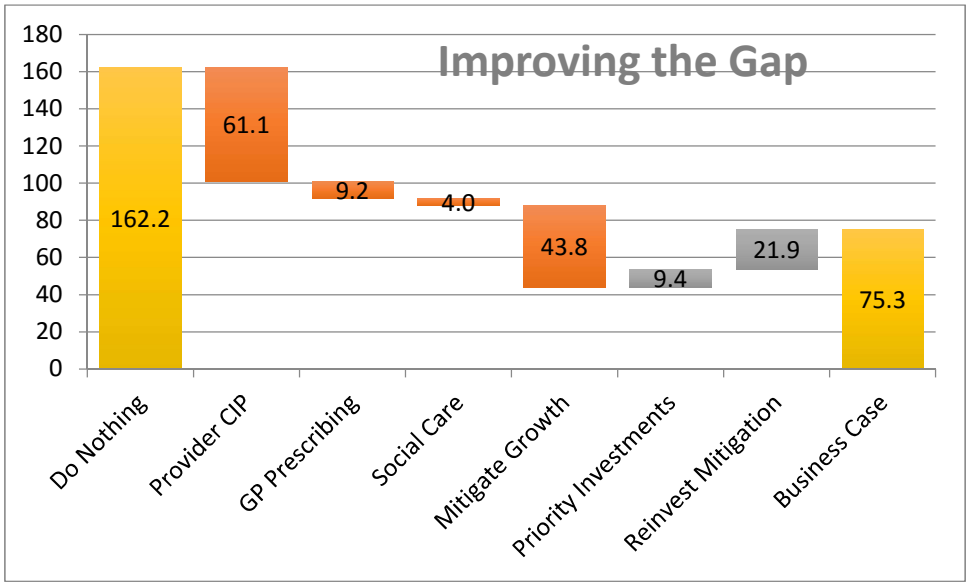
The total impact of the measures above can be seen in the table below. The NHS financial gap reduces to £51m, with an estimated £24.5m social care funding gap**.**

Do Something Gap	16/17 £m	17/18 £m	18/19 £m	19/20 £m	20/21 £m
NHS Gap	**-8.8**	**-12.0**	**-22.5**	**-44.9**	**-50.8**
Social Care Gap	**0.0**	**-3.7**	**-10.2**	**-17.0**	**-24.5**
Total Gap	**-8.8**	**-15.7**	**-32.7**	**-61.9**	**-75.3**

As with the do nothing scenario we can show this graphically across the planning timeframe to see the relative impact on commissioners, providers, and social care, and the bottom line, or taxpayer view.



The movement from the do nothing to the business case scenario is shown in the following diagram.



At the end of the modelled period the relative profile of total expenditure shows a shift from the acute setting to community based providers. This is not as marked as might be expected as the assumptions modelled largely impact on mitigation of growth, rather than on a fundamental shift. A more granular picture will be modelled during October and November 2016.

Provider Expenditure Profile	Do Nothing 2020/21	Do Something 2020/21
Acute Care	56.7%	54.3%
Community Services	12.9%	13.8%
Mental health services	8.7%	8.8%
Primary Care	21.8%	23.0%
Total	100.0%	100.0%

8.8 The Remaining Gap

This business case makes a significant contribution to closing the gap between income and expenditure in the Coastal West Sussex system, but it is recognised that it does not close the gap entirely, nor does it achieve the STP organisational control totals.

Those organisations subject to a control total have a total in year deficit of £12.8m by 2018/19, and a total in year variance to control total of £35.5m.

Control Totals £m		16/17	17/18	18/19
Financial surplus/(deficit) - Gap				
Commissioner	CCG	-7.0	-25.8	-25.6
	NHSE	0.0	-3.4	-5.3
Sub-total		**-7.0**	**-29.1**	**-30.9**
Provider	WSHT	-2.7	13.8	13.0
	SCFT	1.0	3.1	3.4
	SPFT	0.2	1.4	1.7
Sub-total		**-1.5**	**18.3**	**18.1**
Total		**-8.5**	**-10.9**	**-12.8**
STP Control Totals				
Commissioner	CCG	6.9	0.0	0.0
	NHSE	1.9	1.9	2.0
Sub-total		**8.8**	**1.9**	**2.0**
Provider	WSHT	3.2	15.8	16.9
	SCFT	1.0	2.0	2.2
	SPFT	0.2	1.3	1.6
Sub-total		**4.4**	**19.1**	**20.7**
Total		**13.2**	**21.1**	**22.7**
Variance from Control Totals				
Commissioner	CCG	-13.9	-25.8	-25.6
	NHSE	-1.9	-5.3	-7.3
Sub-total		**-15.7**	**-31.1**	**-32.9**
Provider	WSHT	-6.0	-2.0	-3.9
	SCFT	0.0	1.0	1.2
	SPFT	0.0	0.1	0.1
Sub-total		**-6.0**	**-0.9**	**-2.6**
Total		**-21.7**	**-32.0**	**-35.5**

Following all the mitigations as outlined in the Do Something scenario, there still remains a significant gap in 2020/21 of £75m. Additional options to close the gap further are still to be explored and the current case is based on what the Coastal system knows can realistically be achieved at this stage. A further stretch on internal efficiencies across the system and a more ambitious financial impact resulting from models of care would be required to mitigate the financial gap, and achieve the control totals.

9 Implementation Plan and Risk Management

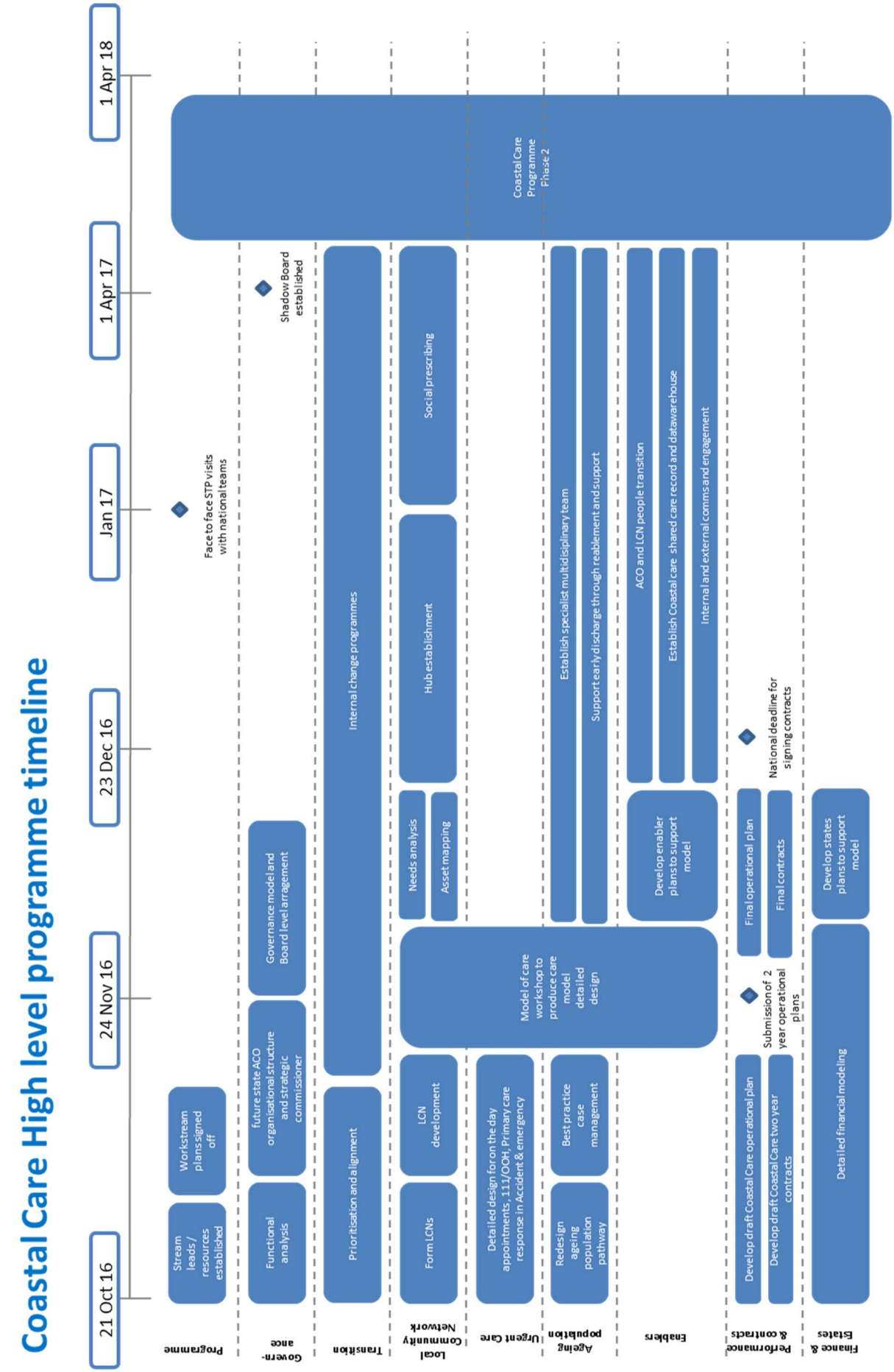
9.1 Implementation Plan

This Coastal Care Programme will be implemented in a phased approach to deliver system transformation and an Accountable Care Organisation by April 2018.

PHASE 1	PHASE 2	PHASE 3	PHASE 4
Development of Coastal Care Plan To 31 Oct 2016	**Operational design** Nov 2016 – Mar 2017	**Shadow Board and care model implementation** 2017/18	**Accountable Care Organisation fully operational** From April 2018
▪ Understanding of the context and system gaps, including financial gap ▪ Identification of the improvement opportunities ▪ Development of the model of care ▪ Confirming arrangements to develop Accountable Care Organisation ▪ Developing Coastal Care Plan (this document)	▪ Detailed design of LCNs, service priorities and delivery plan ▪ Development of enablers for the model of care: payment and contracting models, workforce plan, ACO governance, digital technology plan ▪ Alignment of staff to deliver programme and implementation of OD plan ▪ Memorandum of Understanding signed by all partner organisations ▪ Transition/Shadow Board established ▪ Single operational plan for 2017/18 developed ▪ Full Business Case for ACO developed	▪ Transition/Shadow Board in place ▪ Implementation of LCNs and wider model of care ▪ Implementation of workforce plan and staff training ▪ Delivery of operational plan ▪ Detailed design of Accountable Care Organisation and planning implementation of changes to organisational form ▪ Recruitment and development programme for staff ▪ Single Care Record viewer in place ▪ Use logic model to assess impact of programme ▪ 2018/19 operational plan developed	▪ Accountable Care Organisation established ▪ Year 2 of model of care changes implemented ▪ New capitation and outcome based contracts in place ▪ Experience for staff and citizens improved ▪ Hospital utilisation reduced

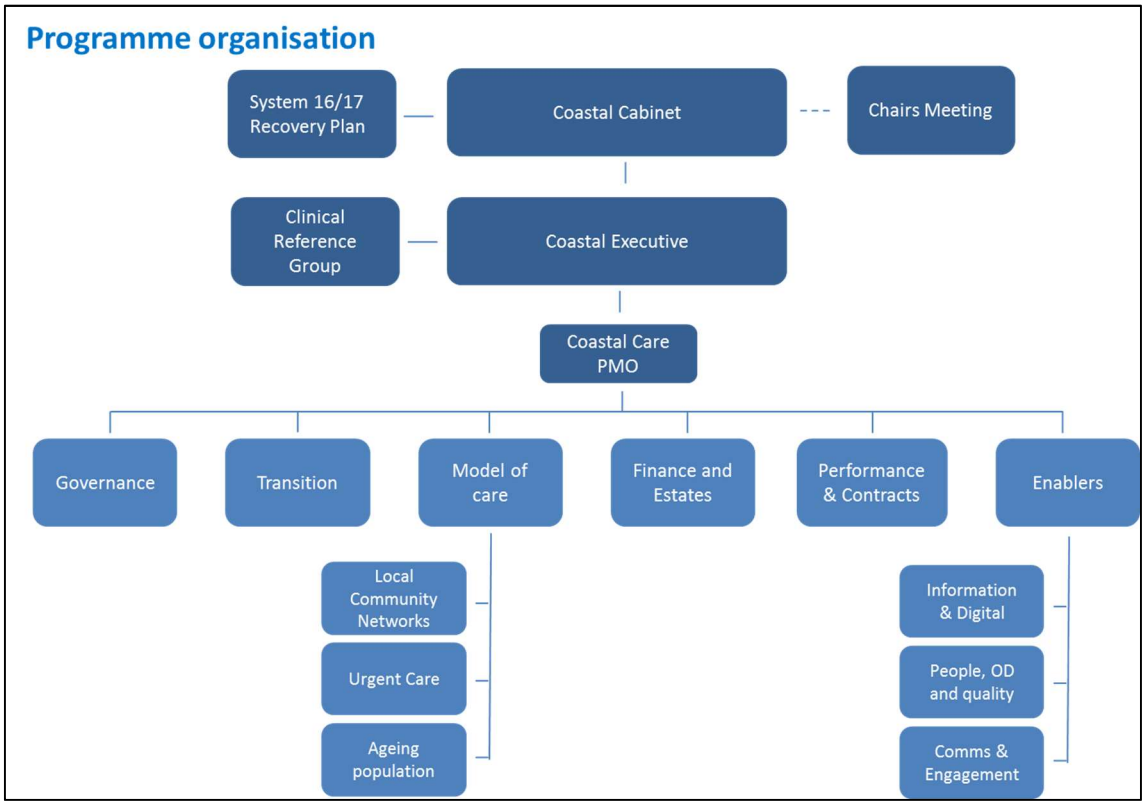
The high level programme timeline overleaf describes the major programme milestones. A Coastal Care Project Initiation Document (PID) has been developed describing the arrangements through which the programme will be managed and governed. The PID describes six immediate priorities for the programme in the period to 31 March 2017, around which the programme activities will be organised:

- Priority 1: To establish the Shadow Accountable Care Organisation Board
- Priority 2: To establish Local Community Networks
- Priority 3: To transform urgent care
- Priority 4: To transform services for the ageing population
- Priority 5: To put in place the necessary enablers to support change
- Priority 6: Delivery of the 2016/17 System Recovery Plan


Coastal Care High level programme timeline
21 Oct 16
24 Nov 16
23 Dec 16
Jan 17
1 Apr 17
1 Apr 18
Programme
Govern-ance
Transition
Local Community Network
Urgent Care
Ageing population
Enablers
Performance & contracts
Finance & States
Stream leads / resources established
Workstream plans signed off
Functional analysis
future state ACO organisational structure and strategic commissioner
Governance model and Board level arragement
Face to face STP visits with national teams
Shadow Board established
Prioritisation and alignment
Internal change programmes
Form LCNs
LCN development
Needs analysis
Asset mapping
Hub establishment
Social prescribing
Detailed design for on the day appointments, 111/OOH, Primary care response in Accident & emergency
Model of care workshop to produce care model detailed design
Redesign ageing population pathway
Best practice case management
Establish specialist multidisiplinary team
Support early discharge through reablement and support
Develop enabler plans to support model
ACO and LCN people transition
Establish Coastal care shared care record and datawarehouse
Internal and external comms and engagement
Develop draft Coastal Care operational plan
Develop draft Coastal Care two year contracts
Submission of 2 year operational plans
Final operational plan
Final contracts
National deadline for signing contracts
Detailed financial modeling
Develop states plans to support model
Coastal Care Programme Phase 2

9.2 Programme Governance

The figure below summarises the programme organisation in the next phase of the programme – the period to April 2017 when the Shadow Board is operational.



The roles and responsibilities of each of the key groups is set out in the table below:

Group	Responsibility
Coastal Cabinet	▪ Delivery of health services across the Coastal West Sussex population ▪ Delivery of transformation programme ▪ Provide oversight for 16/17 recovery plan
Chairs Meeting	▪ Oversight of Coastal Cabinet and alignment with STP
Clinical Reference Group	▪ Clinical oversight for programme – in particular the model of care work stream
System 16/17 Recovery Plan	▪ Delivery of system wide projects to achieve financial and performance objectives 16/17
Coastal Executive	▪ Overall delivery of change programme and in year delivery
Project Management Office	▪ Document management and tracking of decision making ▪ Ensure clarity of deliverables from each organisation

9.3 Key Programme Risks

	Risk Title	Likelihood (1-5)	Severity (1-5)	Risk Score (1-25)	Owner	Mitigating Actions	RAG
1	Despite significant local patient engagement plans and strong benefit realisation stories the message to the people of Coastal Care could be disrupted without the support of a national communication plan.	3	4	12	Comms	Request this risk is added to STP risk register and that they escalate to Central Government. Ensure communication and engagement plans across all Coastal Care organisations are joint and all messages are consistent.	A
2	Although Adur and Worthing District Councils are fully engaged with the programme there is a risk that: Arun; Chichester; Horsham and Mid Sussex do not have a full understanding of the potential impact of Coastal Care	2	5	10	Planning and Contracts	Seek assurance from Adur and Worthing District Councils that they are fully engaged with the other 4 district councils. Reaffirm at each programme stage how these 4 would like to proceed.	A
3	Contractual legislation has not kept up with Vanguard sites, this could significantly impact the delivery of an ACO.	4	5	20	Planning and Contracts	Central Government organisations are aware of this. Vanguards are developing alternative routes around this risk. Coastal Care will continue to monitor this situation as it progresses through it's delivery plans.	R
4	There is a risk that the indicative pooled budget cannot be agreed by all parties.	3	3	9	Finance	Jointly work with contracts and legal teams from each organisation to overcome this risk whilst acknowledging statutory functions.	A
5	A single IT system across each LCNs may be difficult to achieve without funding and full support from General Practice Providers.	5	3	15	Info and Digital	Consult with and gain agreement from all Providers which clinical system they wish to use. Attempt to source appropriate funding to support the migration.	R
6	Risk that the system is unable to successfully implement the new model of care sufficiently quickly to address the challenges faced	3	4	12		As new models are designed pilots will be proof of concept and to flush out issues that may arise later in full implementation of new models of care. The resource requirements to achieve the project objectives are being identified and additional support secured where required.	A

10 Conclusions and next steps

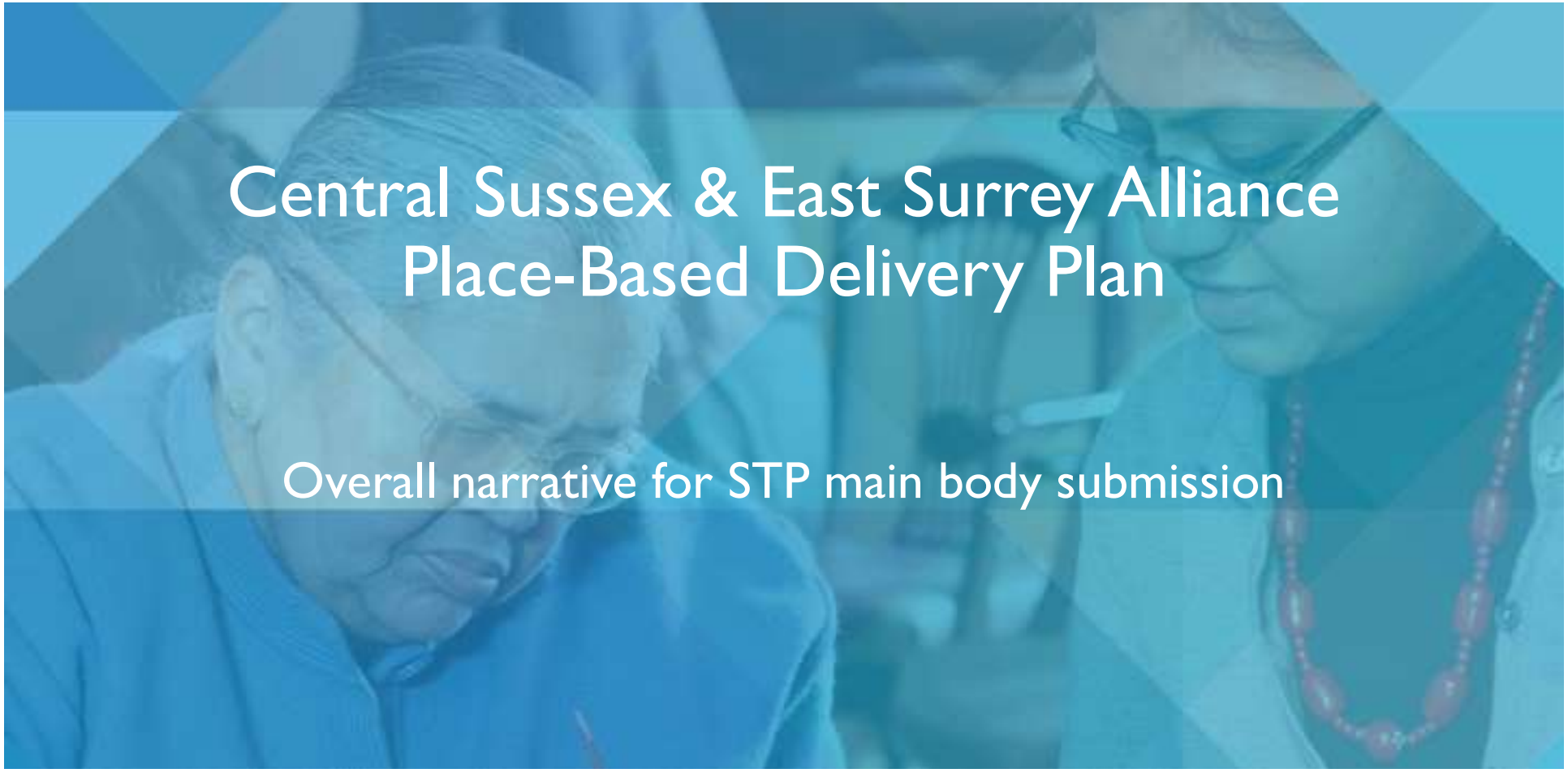
There is a clear case for change in Coastal West Sussex. Providers and commissioners of health and social care are working together to deliver a shared vision to build healthier communities and create sustainable health and care services for the local population. The plan for Coastal Care is fully aligned with the Surrey and Sussex Sustainability and Transformation Plan.

A new model of care has been agreed which promotes physical, mental and social wellbeing and provides proactive support to those at greatest risk through eight Local Community Networks in Coastal West Sussex.

An Accountable Care Organisation will be established through which partners will take accountability together for the health and care for the Coastal West Sussex Population. The Accountable Care Organisation will operate in shadow form from April 2017 and be fully operational by April 2018.

A programme implementation plan, Programme Initiation Document and Programme Governance arrangements are in place to deliver this plan for Coastal West Sussex. The programme priorities for the remainder of 2016/17 have been agreed and work to implement the new model of care and establish the Shadow Accountable Care Organisation is underway.

The arrangements to establish the Accountable Care Organisation are being described in a Memorandum of Understanding which will be ratified by all partner organisations in Coastal West Sussex.



Central Sussex & East Surrey Alliance Place-Based Delivery Plan

Overall narrative for STP main body submission

Central Sussex & East Surrey Alliance

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Central Sussex & East Surrey Alliance

Executive summary

Case for change

- Continuing to **operate as we currently are is not an option**. The **funding and capacity gap** if we do nothing will become insurmountable.
- **Case mix and complexity will increase**, driving the demand for beds higher than just the total population growth. But the **acute sector is already straining to provide capacity**.
- The population is **growing**, and **growing older,** and the overall health of the population is deteriorating
- **Care quality issues** need to be addressed & **social factors** are having a direct impact on health
- Patients are not always receiving the **levels of care** that they want
- Central Sussex and East Surrey Alliance is the **right place** to deliver the future **health and wellbeing needs of its population** but the local health and social care **system is under pressure**.
- **Workforce issues**, organisations in special measures and a lack of **organisation and data integration** complicate the picture
- There are **significant organisational and infrastructure challenges** which the place-based plan needs to address

Vision & priorities

- A **less reactive**, less **hospital bed-based** system which promotes **well being**, **self care** and care at **home**. A system which places **integration** at its centre, providing care and services closer to home. **Led by primary care**, building on good work in progress, promoting **collaboration** across health and social care.

Strategic Objectives	Care designed for the local populations, including families, children & carers	Meaningful integration of providers	Sustainability of primary care	Sustainability of acute care	
Priorities	Prevention and education	LTCs and EOLC managed in the community	Coordinated care for frail & complex patients	Better access to Urgent Care	Cancer, RTT and A&E targets

MCP is the right model

- The components needed to meet our strategic objectives and deliver our priorities are a **close match with the components of an MCP**
- **Primary care** services are already **moving in the MCP direction**
- **Primary care are best placed to lead** the system

The **key outcomes** are:
- Accessibility
- Continuity
- Coordination
- Workforce
- Sustainability
- Quality

The **key components** are:
- Data-driven care model
- Organisational consolidation
- Devolved finance & contracting
- MPC integrator
- Balanced workforce
- Patient at the centre

Key **needs**:
- Bottom-up integration
- Workforce without borders
- GPs are core to the model
- Full data integration

- We have strong foundations for an MCP model and we will drive delivery from care hubs
- We plan to determine the number of MCPs by 09/17, complete public consultation by 03/18 and settle on the legal construction approach by 09/18

Delivery structure

Delivery Streams	Prevention and self care	Continuity for patients with LTCs	Coordination of frail and complex patients	Improved access to urgent care	
Enablers	OD & Leadership	Change Management	Workforce	IM&T	Estates

What it will take to execute

Investment in primary care is absolutely essential to the success of changing the system. Our GPs will provide **clinical leadership**, and they are at the heart of **care hubs – our engines for delivery**.

We need to address **challenges** in all areas in order to be able to deliver this whole-system change

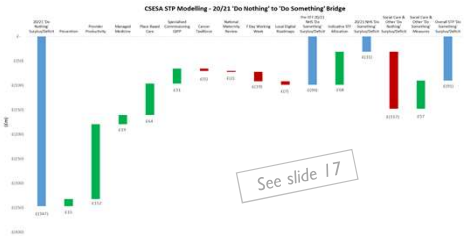
Clinical leadership	Workforce	Change Management	Programme delivery
Technology	Estates	Investment	Contracting

Finances

Nine levers are being used to drive our model for acute savings and community re-provision

Frailty	A multidisciplinary, ambulatory approach	Non Elective admission	Ambulatory care	Long Term Conditions	Increasing patient self management
Elective Reduction	Cascade of electives to day cases to out patient to community	A&E	Improved access to urgent care	Complex Patients	Care coordination and multi-disciplinary teams
Step Down Care	Alternative setting	Outpatient Appointments	Extended primary care	PBR Excluded Drugs	Medicine Management of non PBR drugs

Our approach will reduce the projected deficit in 20/21 from £91m to £31m



Timeline

Next 6 months	Year 2	Year3	Year 4	Year 5
Strategy	*Co-design*	*Deployment & Shadow contract*	*Stabilisation & new contract*	
Service Scope defined (01/01) ◆ CSESA Strategy ◆	#MCPs defined ◆ Public consultation complete ◆	5 year MCP and acute contracts in place ◆ Delegated budgets agreed ◆	◆ MCPs live	
Programme team in place ◆ CSESA 4 year plan ◆	**Gateway #2a**: Capabilities & contract set up (shadow) Shadow delegated budgets agreed ◆	**Gateway #2b**: Capabilities & contract set up (full MCP) **Gateway #3**: Is it safe to commence?		
Gateway* **#1**: Case for Change				

Vanguard ready

We will be formally registering an **expression of interest** in joining the next wave of **Vanguard** projects.

We have:
- A credible **vision**
- A defined **care model**
- Clear **timelines**
- **Work in progress**
- Good understanding of our **financial case**

Case for change: the challenges that we face

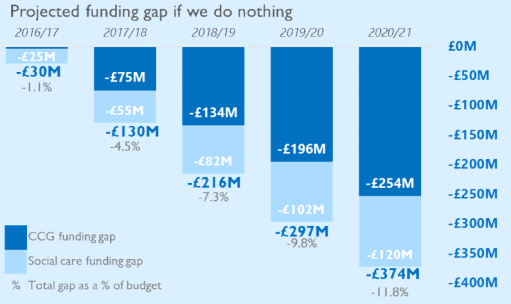
The national and local health and funding issues that must be addressed

Primary care has been underfunded for a long time

- The share of NHS funding for GPs has been cut with respect to acute over the past 10 years. As a direct result, primary care – and its workforce – are under enormous pressure.

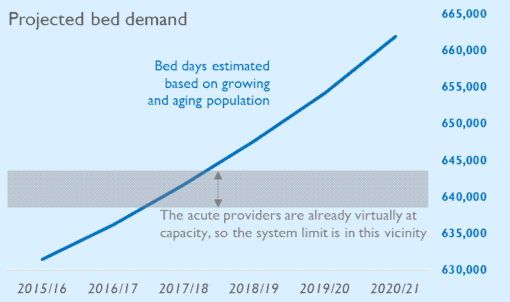
Continuing to operate as we currently are is not an option

- Over the next 5 years, the population is due to grow by an average of 0.9% per annum
- CCG spend is forecast to increase by an average 4.5% per annum, and provider spend by 5.7%.
- This increase in expenditure is forecast to result in a £5m health budget deficit in 2016 and a £254m deficit in 2020



Note: data shows position as estimated in July

- Case mix and complexity will increase, driving the demand for beds higher than just the total population growth. But the acute sector is already straining to provide capacity.



The population is growing, and growing older

- Life expectancy continues to rise. The number of people over 85 will have doubled in Surrey by 2030. In Sussex, the number of people aged 90+ is expected to increase by 50% by 2022 and over 300% by 2037. In more deprived areas this rate of increase is slower, meaning that inequality, as expressed in terms of life expectancy has, and will, continue to increase.
- As the population ages, more people will be living longer with a long-term condition or disability and many people will be living with multiple long term conditions. Many long-term conditions are strongly associated with age, but lifestyle risk factors are important, and some long term conditions are preventable. The number of people with conditions such as diabetes, coronary heart disease and chronic obstructive pulmonary disease is expected to increase over the next five to ten years. A greater number of frail patients will result in a proportional increase in of end-of-life care beds.
- Approximately 6% of the adult population in West Sussex has a diagnosis of diabetes. This is projected to increase ahead of overall population increase. Most diabetes is preventable and the risk factors understood; excess weight, smoking, poor diet, low levels of physical activity.
- It is estimated that 15%-30% of dementia is linked to cardiovascular problems. Therefore current public health interventions aimed at increasing healthy lifestyles may reduce the incidence of dementia.

The overall health of children and working age adults is deteriorating

- We have above average-smoking rates for 15 year olds and some localities have high adult smoking rate. 18% of the population in East Sussex smoke and in Brighton & Hove the prevalence of smoking is 21%; both are higher than the national figure of 17%. One in four adults drink more than the recommended daily drinking guidelines.
- There are above average levels of obesity and self harm rates of hospitalisation.

Cancer and stroke need a particular focus

- Mortality from all cancers in people under 75 years of age is significantly higher in Brighton & Hove than England and the South East, and screening uptake rates generally lower. 25% of patients in Brighton and Hove are diagnosed through emergency routes, above the national average of 20%.
- In line with national findings, we can do much to improve our levels of cancer care to an acceptable standard. Britain has the worst cancer survival rate in Western Europe.
- With 1 in 2 people born after 1960 destined to develop cancer in their lifetimes, this is a wide-ranging issue. Cancer treatment is evolving quickly but it still very costly so early diagnosis will be key.
- 1 in 5 women and 1 in 6 men over 75 will have a stroke. Our ageing population means that the volumes of strokes will continue to increase.

Patients are not always receiving the levels of care that they want

- Patient expectations continue to increase. People expect to be seen and treated more quickly and at a time and place more convenient for them.
- In Crawley, patient satisfaction rates for care inside hospital and in the community are in the lowest quartiles of performance as measured nationally. Ambition is to drive quality of these experiences up towards the national average.
- A lack of coordination across the system contributes to the poor patient experience.

Care quality issues need to be addressed

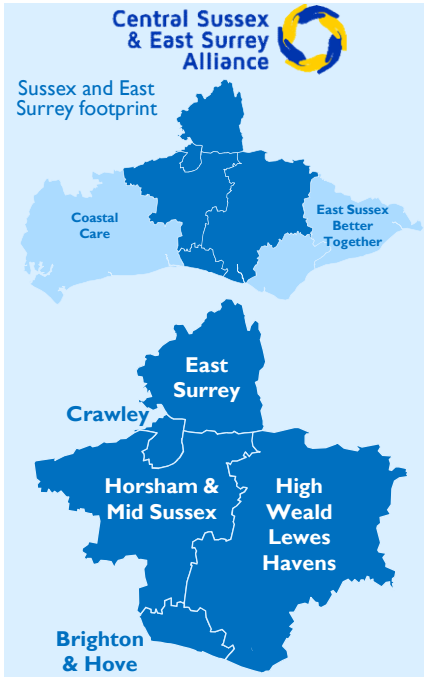
- Cancer and direct diagnostics are insufficient to meet NICE guidelines NG12
- Several other major areas of care have been identified as requiring improvement:
  - mental health detection, access and outcomes
  - LTCM prevention and support
  - support to frail and complex patients
  - maternity and children's services.

Social factors are having a direct impact on health

- Social care is also under pressure: funding levels are declining and this is a significant driver behind deteriorating health issues.
- Homelessness has increased, including rough sleeping, presenting significant risks to individuals' health and wellbeing, as well as challenges for health and social care services. For example in Brighton & Hove street services worked with 775 people during 2014/15; in November 2015, a snapshot of a single night estimated there were 78 people sleeping rough.

Case for change: understanding the CSESA place today

We have the right assets in good locations but there are a number of system challenges



1.2M	people
£1.6bn	annual healthcare spend
117	general practices
5	CCGs
4	local authorities
7	district councils
3	acute trusts
5	acute hospitals
3	hospices
5	community hospitals
2	community health trusts
2	mental health trusts
1	ambulance trust

CSESA was formed as a place-based area in August 2016

CSESA is the right place to deliver a future health and wellbeing service

- Primary care is already starting to come together at scale through in each CCG:
  - East Surrey: 4 Primary Care Networks have been established and the GP Federation selected as most capable provider of enhanced primary care services
  - Crawley: the 2 Communities of Practice are working together on introducing social prescribing
  - HMS: 4 Communities of Practice including a PCH Vanguard in East Grinstead. Exploring early shadow capitated budgets.
  - HWLH: 4 Communities of Practice pilot – Connecting 4 You
  - B&H: 6 clusters delivering services as Brighton & Hove Caring Together
- The three acute trusts are building a network where they are able to plan and deliver higher quality, sustainable services at scale. BSUH and QVH are drafting an MoU to cover short term elective capacity and strategic relationship.
- Transport links support the flow of patients up and down the corridor, provided by the A23 and M23 alongside a good rail infrastructure between London and Brighton.
- There is a wide range of inequality and diversity when looking across the footprint as a whole. There are deprived and highly affluent areas. There is also a mix of urban and rural geography. A larger place covering all of these aspects allows services to be commissioned and provided at a scale; services which are more wide-reaching and capable of delivering better outcomes for patients. Where there are currently a few people in need, a more sustainable service can be provided across a greater population.
- The wider place allows for increased partnership working, better utilisation of assets and new ways of defining and using budgets to commission services. Collaboration around the infrastructure and shared sites for health services will provide greater access to a wider range of services.
- By planning for services at this scale, we believe it will be possible to return the system back into financial balance. Capitated budgets and programme level budgeting will be possible through pooling resources. Designing services at a scale of 1.2M people with delivery localism will make it easier to invest in primary care.

But the local health and social care system is under pressure. There are significant challenges which the place-based plan must address.

- The historical under-investment in primary care has left it in a precarious state. All of the issues recognised in the GP Five year Forward View are manifested in our place.
- Recruitment and retention of clinicians is challenging: GP lists are closed and practices are closing (seven recently in Brighton) as the aging GP & nurse population retires. 17% of GPs and 39% of practice nurses are forecast to retire in the next 5 years, with no identified source of replacement.
- In our hospitals, patients are waiting too long for planned care services and are not being seen quickly enough when they attend A&E. Mandatory performance indicators such as RTT and the 4 hour A&E department standard are not being consistently met.
- As the BSUH 3Ts development progresses and decants further capacity, the broader STP will demonstrate how we will provide additional capacity in the short and long term.
- The August CQC inspection rated Brighton & Sussex University Hospitals Trust overall as Inadequate. The CQC noted that patients were not receiving the quality of care that they are entitled to expect, or within the timescales required.
- South East Coast Ambulance Trust is rated Inadequate by the CQC and has been placed into special measures.
- NHS Brighton and Hove CCG and East Surrey CCG are both rated as Inadequate. East Surrey is in special measures for its finances.
- It is not possible to access and share patient data between clinicians across organisational boundaries and patients are unable to access information about their conditions.
- There is a diverse legacy of primary and community estate with premises owned variously by GP partners, County Councils, NHS Property Services, and third party landlords including private finance initiatives.
- Whilst there is some opportunity for rationalisation and/or disposal of estate, this is outweighed by the need for substantial investment, both to address the significant local housing planned for the subsequent population growth, and to enable the shift of care from acute to primary and community settings. The development of the Royal Sussex County Hospital is a start, but will need to be accompanied by robust planning to absorb additional care, closer to home.
- Silo workforces, bound by organisational structure, result in multiple hand-offs and lack of understanding of the range of services available to patients.
- Time pressure for staff training or development and demand on services outweighing staffing levels means that stress levels are at an all-time high for many staff.
- GPs are taking on different roles as care hubs evolve and there will be a significant level of training and education required.
- In the current configuration, it is natural for organisations to compete rather than collaborate for the best interests of the patients and the system.
- The 'normal' NHS pace of change is very slow and needs to embrace digital working.

Our vision for CSESA

We will invest to develop a system of healthcare that is less reactive and less hospital bed-based. It will deliver a great start in life and continue to promote people's wellbeing, their ability to stay healthy, to self care and be cared for at home. We will bring together a system which places integration at its centre, providing more care and services closer to patients' homes and places of need. Led by primary care, we will build on the good work already in progress, promoting collaboration between all organisations working across health and social care.

Our strategic objectives

Care designed for the needs of local populations

- Uses detailed, integrated health and social care datasets based on combined GP lists to determine the changing needs of local people – as an ongoing evaluation, not a snapshot
- Applies risk stratification using real-time data and Rightcare methodology to drive proactive interventions to keep people healthy
- Identifies demographic subsets based on factors such as isolation, dependency, and deprivation to determine additional or focused services
- Applies the pay-it-forward principle to developing systems of care for children and families – especially complex ones
- Identifies and supports carers, to protect the pivotal role they play
- Maintains equality of service access and is developed in partnership with the population
- Supports patient choice to ensure dignity and quality of life
- Enables the system-wide carbon management approach

Meaningful integration of providers

- Delivers real organisational and operational integration between primary and community services
- Enables effective integration of mental health, adults and children's social care and acute services into a team around the patient
- Weaves social care tightly with healthcare to address the needs of the whole person and family
- Builds working at scale and removes existing organisation boundaries
- Formalises significant third sector support
- Uses single data systems for a seamless patient experience and real-time handovers
- Links people to a range of support services via social prescribing

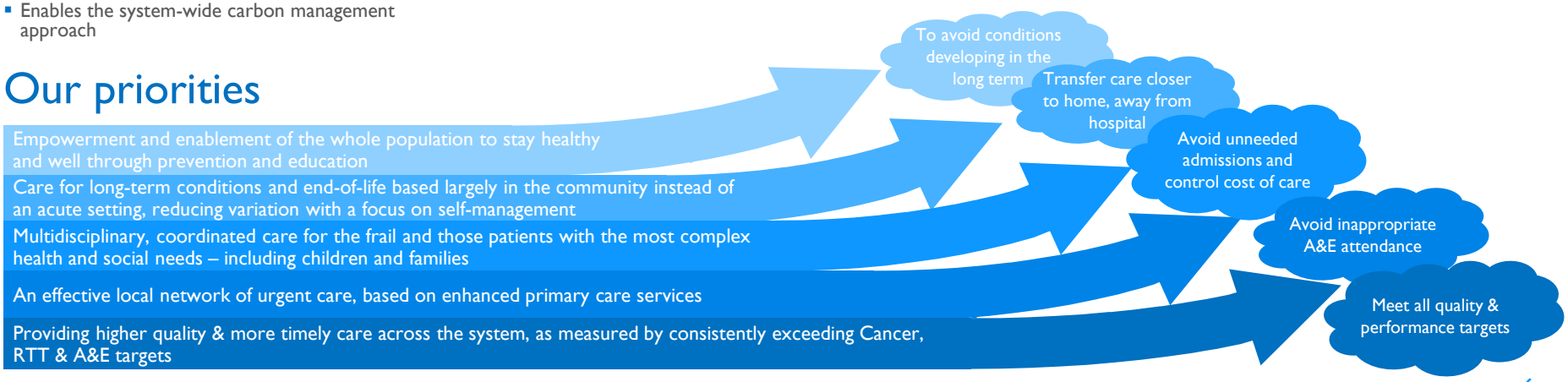
Sustainability of primary care

- Reduces people's dependence on the system and its services
- Empowers and supports front-line primary care to take a system leadership role
- Builds broader, resilient general practice at the heart of the MCP model
- Releases GP capacity through an increased use of skill mix
- Enables GPs to focus on complex patients and planned care
- Increases capacity and capabilities in primary care to enable delivery of services currently in acute – including direct cancer diagnosis and some levels of speciality current in secondary

Sustainability of acute care

- Enables acute providers to meet and exceed the constitutional quality & performance thresholds
- Transfers significant levels of activity from acute to community setting
- Reduces total healthcare spend to enable long-term sustainability
- Reduces pressure on the acute system to allow focus on specialist acute care
- Provides care closer to home and minimises the need for admissions
- Dovetails primary & community care closely with acute capability and capacity to balance supply with demand

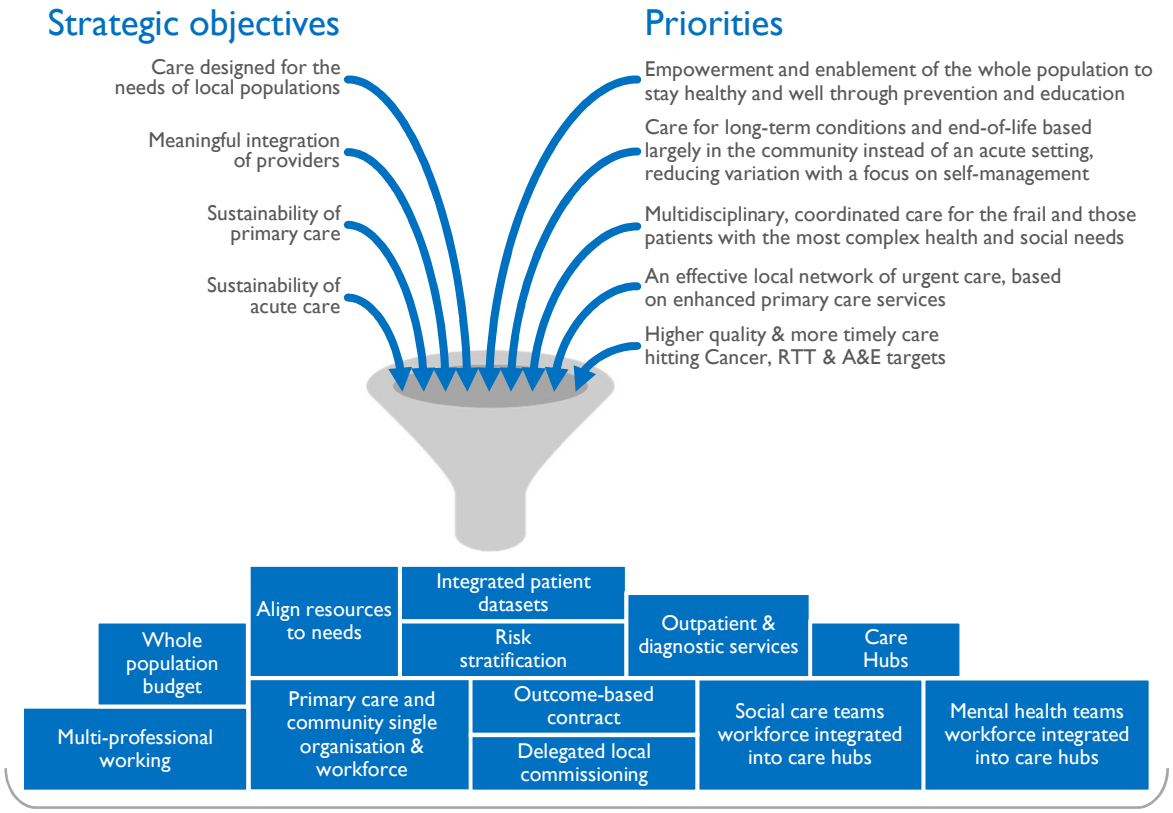
Our priorities



Why an MCP is the right model for accountable care

The current system cannot deliver the change required. There are three reasons why a multispecialty community provider (MCP) model is the best solution to both meet the local healthcare needs of our diverse population needs, and to render the system sustainable.

1 We have a shared vision which closely aligns to the MCP model and whose objectives and priorities can be met with the components of an MCP



Components to deliver our vision = components of an MCP

2 We are already building strong foundations for the MCP model

- The Brighton & Hove Caring together project already has services being delivered in integrated 'clusters'
- In Horsham and Mid-Sussex, East Grinstead have set up the Primary Care Home model with vanguard funding, and are planning to expand.
- High Weald Lewes Havens are fully co-commissioned; Brighton and Hove have recently voted to transfer to co-commissioning; Horsham and Mid Sussex are voting in October and Crawley are in discussions with GPs.
- In East Surrey, all practices are members of a Federation which has just been awarded most capable provider status for all enhanced primary care services, as a precursor to the CCG replacing individual practice LCS contracts with an umbrella contract with the Federation.

3 We have strong leadership from our primary care clinicians

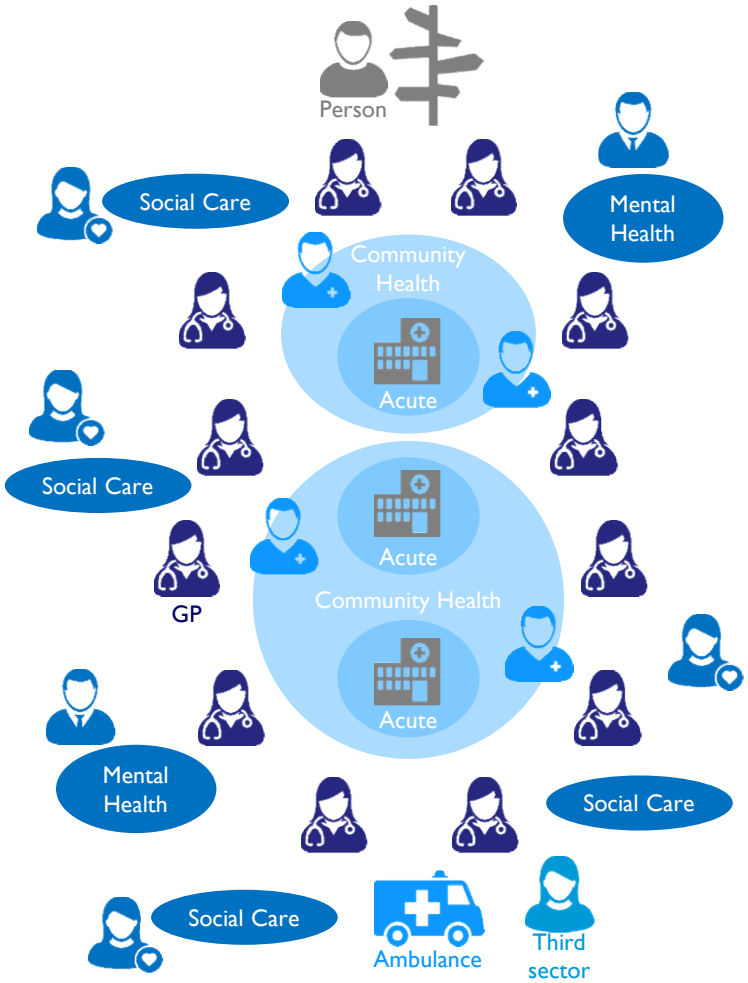
- There is very strong support from GPs across the CSESA place.
- GPs are the driving force behind change and will be providing the clinical leadership to drive the pulling of activity from the acute setting.
- Two-thirds of the workload on the system is as a result of LTCs which by their nature should be driven as a population-focused service. Primary care is best placed to coordinate that.
- We need to give the acute trusts the space to develop sustainable and networked models of care that integrate with the MCP model.

What will be different in an MCP

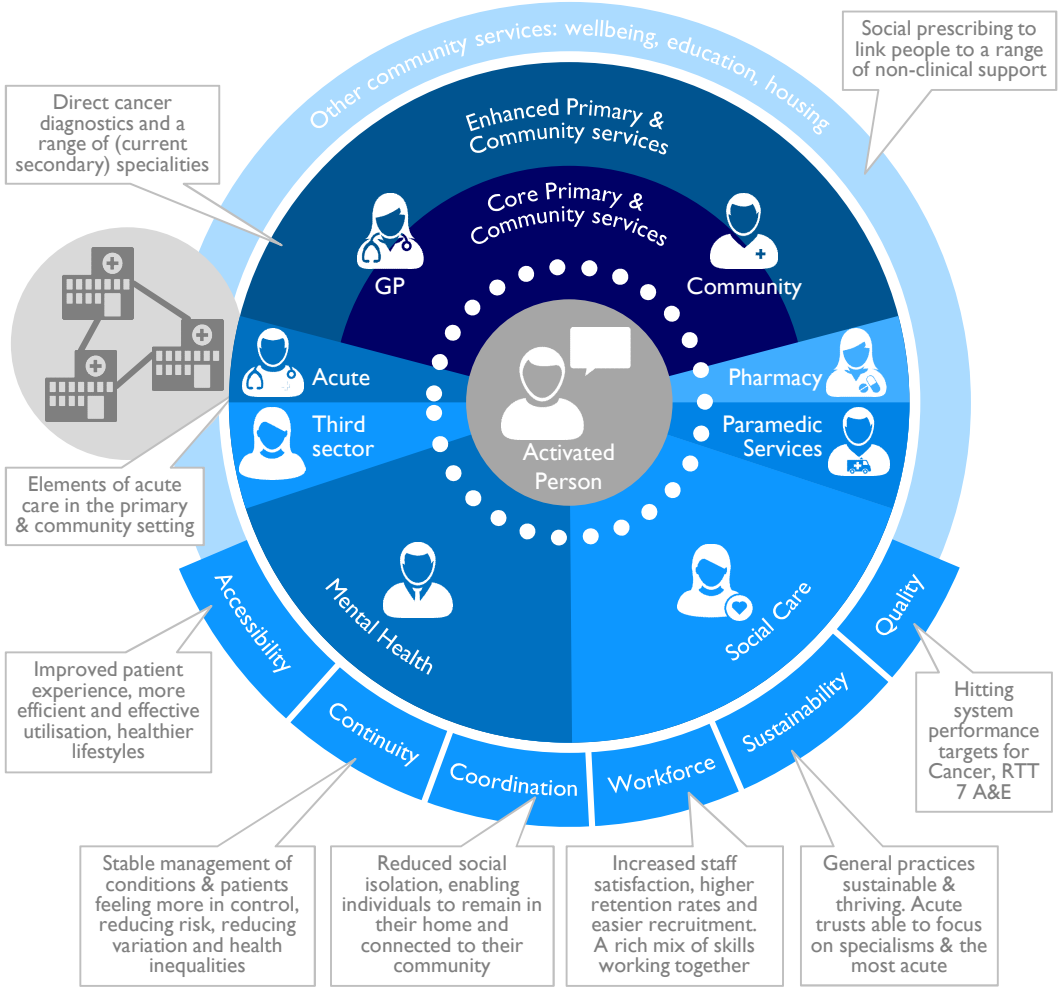
The MCP model arranges care around the person and integrates out-of-hospital services

This is today

The patient experience is very much one of disjointed organisations, with little sense of a joined-up service



This is our future



What the MCP will look like

The key differences in how an MCP will work

Organisational consolidation

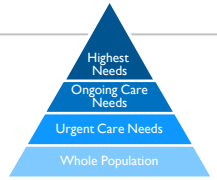
- Integrated primary and community care via networks of general practices. This may mean federations or super practices joining organisations with community providers – or it may mean a prime/subcontractor model
- Organised into 20 care hubs of 30-50k, with a minimum total population of 100k
- Mix of informal alliances, federations, or super-partnerships – working as partners, subcontractors or employees – according to the choice of local general practices
- Closely aligned mental health care and social care, with a consistent MDT structure
- Clinically-led local care hubs
- Collaborative, shared leadership and management across the MCP
- Designed-in connection to and use of the voluntary sector
- Shared estates & back office functions
- Community diagnostics and outpatient services

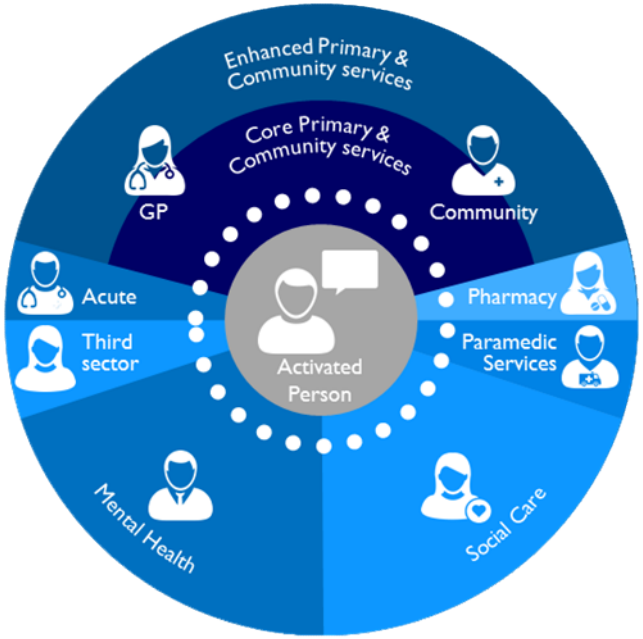
MCP Integrator

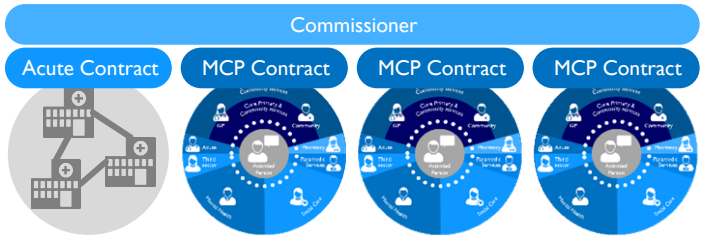
- The model will include a provider-based function to oversee all in-MCP services and respond to commissioner, effectively running delegated commissioning and taking make-or-buy decisions
- Uses dynamic analytics so that continuous data is available info to clinicians, organisations, system and used to adjust services
- Coordinates delivery, defines performance agreements, manages payments, organises networks and membership, trains practice staff

Data driven care model

- Clear and deep understanding of the population needs with risk stratification
- Prevention and care designed for segmented population
- Analytical, predictive models to target variation
- Single technology stack and integrated digital care record across primary, community, social care and acute







3 MCPs shown not indicative of anticipated number

Patient at the centre

- Better patient experience, with the patient's and population's needs determining the services and delivery in a location closer to home
- Activates patients, carers and families
- Uses digital technology to transform contact, diagnosis and treatment
- Supports the patient choice agenda, whilst working in partnership with patients and their families about the most appropriate place of care

Balanced workforce

- Locality managers
- Single workforce with a richer skill mix (GPs, nurses, paramedics, pharmacists, consultants, social prescribers, etc.)
- Redesigned jobs and workforce mobility within and MCP
- Close working with acute, even employing consultants

Devolved finance & contracting

- Broader and larger in scope, joint outcome-based contracts between the CCGs and the MCP, with separate contracts for acute
- Holding single whole-population capitated budgets, with a new performance framework. Discussions are already underway for early shadow budgets.
- Collaborative commissioning and co-design
- Greater responsibility for performance monitoring & management
- Flexibility to manage whole resource pool according to budget

We have strong foundations from which to grow our MCP

We will focus on building the care hub locality services first

- Although CSESA is a relatively new group covering a large and very diverse area, there is a great deal of work to transform services already underway and much good practice to leverage. Social care and mental health are already integrated to varying extents and we are in the process of aligning contracts.
- The parallels and cooperation across CCGs and providers are what has brought us together as a place footprint and is why leaders are aligned on an MCP model as the right answer. This will incorporate the 20 existing care hubs and will be arranged around a robustly networked acute service.
- We want to drive delivery from the care hubs upwards. We are already having conversations about how some of them could be given early delegated budgets to provide services at this local scale.
- There are three key milestones:

Determine number of MCPs
We will perform additional population modelling and compare the options for MCP configuration

Sep 2017

Hold Public Consultation
Gather patient and public feedback on the rationale for, approach to, construction of and number of MCPs

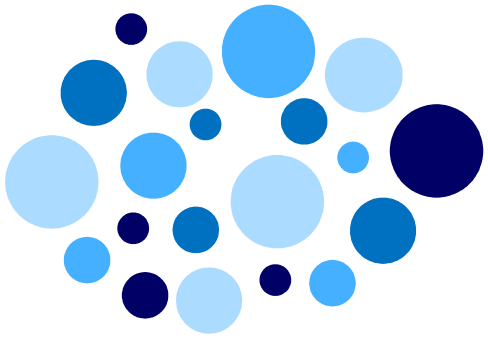
March 2018

Dates TBC subject to purdah

Decide the legal form that each MCP will take
In partnership with providers, establish whether a virtual, partially integrated or fully integrated model works best in each MCP. There is appetite for full integration.

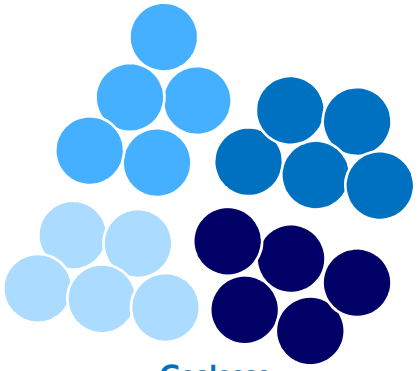
Sep 2018

- We will build MCPs from the ground upwards, starting with establishing sustainable care hubs:



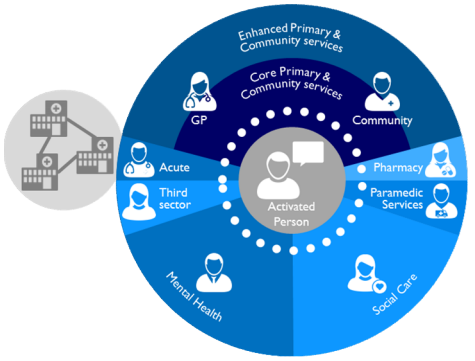
Stabilise

We will focus our immediate effort on laying the firm foundations: establishing strong, sustainable care hubs that deliver services at local scale.



Coalesce

As communities develop and stabilise, we will determine how they informally come together into large groups – taking into account national evidence and learning.



Reorganise

The groups will pivot into a formal MCP structure(s) with transfer of workforce into new organisations

How our organisational capability will mature

Comparing where we are now with our ambition highlights the change that is needed

The WISH maturity model sets out 5 capability 'ladders'

- This is a framework for maturity progression for population-based accountable care
- It is a robust framework for planning out the changes that are required to move from our current set of capabilities to those needed to operate our MCP model
- Each step up each of the 5 ladders will mean a significant change to organisation, leadership, ways of working for all staff, use of technology and estates

The LGA and NHS Confederation Integration self-assessment tool will be used to help plan these changes

- This tool will be used to assess the readiness of the leadership, system and programme team for setting out on and managing the complex programme of change

Where we want to be

Where we are now

	i Population	ii Outcomes	iii Metrics and learning	iv Payments and incentives	v Co-ordinated delivery
5	**Intersections accounted for** (ie, co-morbidities)	Outcomes that **matter to people**; prioritized based on **individual goals**	Aggregated longitudinal data made **public** in cross-provider **consistent** format	**Full capitation** with guard rails on quality; differential payments for outcomes	Clinical and data **integration of provider network**; patients **co-design** care
4	**At-risk** individuals identified, using all available sources	Focus on **prevention** and **wellness**; goals adjusted based on patient **risk** level	Results shared with people in **usable** form; monitoring **built into** clinical work flow	Upside and **downside** shared savings; strong professional competition	Patients **empowered** to self-care; **care plan** and **managed transitions**
3	**Registry** of population **integrated** with EHR	**Comparable** with other providers and aligned with global **best practice**	**Real-time** and **summary** learning; results **shared** with payer and clinicians	**Upside-only** shared savings and risk for whole health; bonuses to staff	**Clinicians empowered** to adjust interventions to improve outcomes
2	**Defined** population (eg, morbidity, age, geography, payer)	Incorporation of **patient experience** into targets	**Leading clinical indicators** with **evidence link** to outcomes	**Bundled payments** with quality controls for episodes of care	Multi-disciplinary **meetings**; all team members used to **maximum** potential
1	**Holistic view** of existing funding and providers	**Basic clinical outcomes** decided at local level	**Admin-based** measures; **limited** transparency; summary evaluation only	**Pay-for-performance** bonuses **on top of** fee-for-service or block payments	**Basic electronic data-sharing** across providers
0	No identified population	No target outcomes	No metrics nor learning	Payments for activity only	Uncoordinated provision of elements of care

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The clinical approach within the MCP model

We have 4 clinical priorities

	Whole Population	Urgent care needs	Ongoing Care needs	Highest needs
Link to the wider System	Significantly increased prevention initiatives | Integration with public health | Social prescribing and signposting to social and third sector services | Tailored health coaching to encourage self-care	Networked UTC/WIC/MIUs | Broadening direct patient access to services | Diagnostic centres to provide quicker and easier access	Consultants providing advice / support working in the community to the same outcome basis as general practice | Increasing shared decision making in elective pathways | More EOLC at home/in community integrated to hospice care	Geriatricians supporting MDT-led frailty pathway | Community beds model reviewed and services optimised with emphasis on care at home but providing short term specialist support | Responsive services teams & specialist nurses supporting patients needing urgent care in their own homes, preventing admissions and immediate discharge
Locality	Targeted health education based on population data	Locality wide improvements to on the day access towards 7/7 working | Better utilisation of existing walk-in facilities	Connecting to other public services and the voluntary sector | Access to extended care hub team | LTC management through wider skill mix based around practices	Lead GP co-ordinating locality approach | Care hubs as locus of coordination | Practice collaboration in areas such as a visiting service | Integrated health & social care packages | Greater mental health involvement in MDTs
Practice	Increased focus on routine and complex patients (due to urgent on-the-day demand moving to single locality solution)	Different skill mix to enable easier access | digital access to primary care and online diversion to self-care | Load balancing supply across locality	Named primary point of contact. Increased skill mix in practice (nurse practitioners, paramedics, physician assistants etc.)	Locality care coordinators to manage the day-to-day provision of care and act as single point of contact for patients
GP	Increased role in leadership of designing and delivering local services | Increased flexibility to shift between: focussing on routine and complex patients | Providing on-the-day urgent access for locality | Roving GP for home visits		Focused attention on better outcomes/management of LTCs such as respiratory conditions & diabetes (LCS)	Lead professional as co-ordinator of care (not always GP) | Focused attention on better management of complex high cost patients (LCS)
Person	Prevention & self-care	Accessibility	Continuity	Coordination
Examples of services/ projects already in place or in progress, and ready to scale	Care hubs: East Surrey GP Federation Networks | Crawley Communities of Practice | HMS Primary Care Home vanguard | HWLH Connecting 4 You | Brighton and Hove Caring Together Social prescribing | Health coaching and patient activation | Smoking cessation | Homeless GP practice | LCS funding weighted by population need | Care without Carbon	Commitment to place-wide diagnostic centre | Paramedic practitioner Whitstable model | Roving GP | Rapid response community services and tech-enabled care link | A&E GP front door services |Trials of digital consultation channels | Pharmacy moving into community locations | 24-hour single point of access for Mental Health | Safe havens and street triage	MSK pathway | Cardiology triage and ambulatory ECG | Acute referral management | Community geriatrician | Perinatal mental health | Integrated children's mental health | CAHMS transformation plan | Golden ticket dementia service | Community transport | Enhanced nursing home care | Care homes prescribing | End of life care strategy | Tier 2&3 diabetes community service	Complex patients care coordination at practice level | Care-hub MDTs for most complex patients | Lead professional

We will deliver the clinical changes by driving delivery at a local, care hub level within an outcomes-based framework, with consistency, support and enablers managed at a programme level. The clinical work will fit into one of four delivery streams:

Delivery Streams	**1. Prevention and self care**	**2. Improved access to urgent care**	**3. Continuity for patients with LTCs**	**4. Coordination of frail and complex patients**
Enablers	OD & Leadership	Change Management	Workforce	IM&T	Estates

How our place-based plan will support sustainability of acute care

There is whole-system support for the BSUH recovery plan and building a sustainable acute network

The acute system is **under pressure across our STP**. It is particularly fragile at BSUH, . We recognise the need for **investment** in the BSUH **3Ts** programme and the **Urgent Care Centre expansion** this winter. We also recognise that there is an immediate need to invest in **more beds** as a short term measure but we aim for the place-based system to relieve significant pressure from acute starting next year. We must secure improvements in **patient flows** though the acute sector, which includes plans to **support our ambulance trust** in increasing their performance – for example, working on ambulance handover delays at A&E.

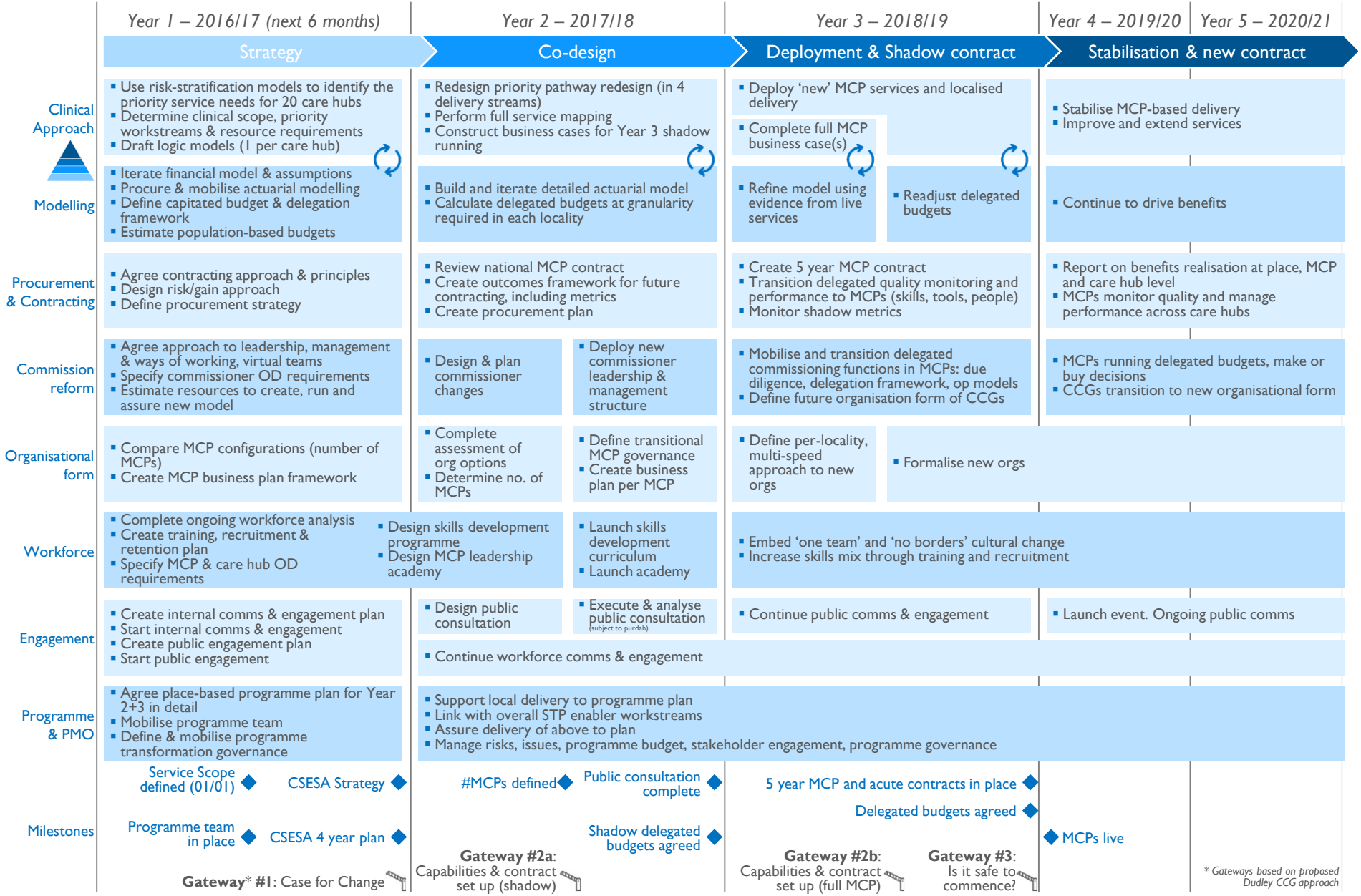
Our model will significantly increase the episodes of care in the out-of-hospital setting, in order to **decrease the demand** on all acute hospitals. Even where resilience is currently good, our plan will ensure that the increasing need and complexity bought by a changing demographic profile will be met while, only increasing activity in secondary care where this is clinically appropriate. We will be looking beyond the health system to **local authorities** and the **third sector** to bring support to a **highly integrated** system.

Our MCP model will have bring **three key benefits** in controlling demand for acute services. It will: **avoid unnecessary attendance**; or **admission**; and **accelerate discharge**

Benefit	Whole Population	Urgent care needs	Ongoing Care needs	Highest needs
Avoid attendance	▪ Increased prevention and self-care will enable people to have increasing disability free life years and, where needed, to access care early, thereby decreasing care need and cost. This is a longer term impact. ▪ Social prescribing will provide people with more rounded health and wellbeing support and will give people a wide range of options so that hospital is not the default solution.	▪ A more integrated approach to urgent care, with improved access to GPs and other local clinicians through the Clinical Navigation Hubs will avoid unnecessary use of A&E ▪ Increased community diagnostics will reduce demand on acute trust diagnostic services currently under enormous pressure such as digestive diseases. It will also detect issues earlier, reducing the amount of acute care needed to treat patients ▪ Paramedic Practitioner Whitstable model seeing patients at home will decrease conveyances ▪ Mental health safe havens will decrease the use of A&E for episodes of crisis ▪ GP on A&E front door	▪ Significant shift of LTC care into the community with specialist support. Working with NHS England in the commissioning and delivery of whole pathways involving specialist services ▪ Elective care system with shared decision making interventions focussed on outcomes ▪ A more resilient range of elective care providers ▪ Reduced barriers between primary and secondary professionals (such as Consultant Connect) ▪ Day case procedures provided by MCP ▪ EOLC with a focus on care in the place of choice will reduce need for patients to come to hospital and support rapid discharge ▪ Enhanced nursing home care will reduce reliance on 999	▪ Community-led MDTs will incorporate consultant input to decrease travel to hospital ▪ Care coordination will ensure timely and joined-up care packages at home, and provide patients with a single point of access ▪ Increasing 'Discharge to Assess' to reduce deterioration and frailty in the acute environment
Avoid admission	▪ Follows from avoided attendance above, but will be a limited impact in the short term	▪ Better integration of community health, social care and mental health led by primary care will make it easier to be able to send patients home with appropriate follow-up care	▪ Increased focus on supported self-management will reduce episodes of crisis that might have needed bed-based care	▪ Proactive integrated care will reduce episodes of crisis avoiding unnecessary bed-based care ▪ Responsive services and specialist nurses will increase treatment at home, avoiding unnecessary short stays
Accelerate discharge	▪ Not applicable		▪ Better integration will make it easier to be able to send patients home with appropriate follow-up care	▪ The integrated MDT and MCP organisation will be a single team helping patients home

Our model includes significant use of acute consultants in a community setting and therefore in time we would expect initiatives such as Hospital at Home to embed as an integral part of the MCP delivery team, led by primary care with support from acute. We will also reduce pressure on the acute day-case units by providing procedures in the MCP. In the short term, key quick wins include increased community diagnostics and more integrated MDT teams for the most complex patients at risk of admission. Both of these will help relieve pressure from the acute setting quickly.

Timescales


Year 1 – 2016/17 (next 6 months)
Year 2 – 2017/18
Year 3 – 2018/19
Year 4 – 2019/20
Year 5 – 2020/21
Strategy
Co-design
Deployment & Shadow contract
Stabilisation & new contract
Clinical Approach
Use risk-stratification models to identify the priority service needs for 20 care hubs
Determine clinical scope, priority workstreams & resource requirements
Draft logic models (1 per care hub)
Redesign priority pathway redesign (in 4 delivery streams)
Perform full service mapping
Construct business cases for Year 3 shadow running
Deploy 'new' MCP services and localised delivery
Complete full MCP business case(s)
Stabilise MCP-based delivery
Improve and extend services
Modelling
Iterate financial model & assumptions
Procure & mobilise actuarial modelling
Define capitated budget & delegation framework
Estimate population-based budgets
Build and iterate detailed actuarial model
Calculate delegated budgets at granularity required in each locality
Refine model using evidence from live services
Readjust delegated budgets
Continue to drive benefits
Procurement & Contracting
Agree contracting approach & principles
Design risk/gain approach
Define procurement strategy
Review national MCP contract
Create outcomes framework for future contracting, including metrics
Create procurement plan
Create 5 year MCP contract
Transition delegated quality monitoring and performance to MCPs (skills, tools, people)
Monitor shadow metrics
Report on benefits realisation at place, MCP and care hub level
MCPs monitor quality and manage performance across care hubs
Commission reform
Agree approach to leadership, management & ways of working, virtual teams
Specify commissioner OD requirements
Estimate resources to create, run and assure new model
Design & plan commissioner changes
Deploy new commissioner leadership & management structure
Mobilise and transition delegated commissioning functions in MCPs: due diligence, delegation framework, op models
Define future organisation form of CCGs
MCPs running delegated budgets, make or buy decisions
CCGs transition to new organisational form
Organisational form
Compare MCP configurations (number of MCPs)
Create MCP business plan framework
Complete assessment of org options
Determine no. of MCPs
Define transitional MCP governance
Create business plan per MCP
Define per-locality, multi-speed approach to new orgs
Formalise new orgs
Workforce
Complete ongoing workforce analysis
Create training, recruitment & retention plan
Specify MCP & care hub OD requirements
Design skills development programme
Design MCP leadership academy
Launch skills development curriculum
Launch academy
Embed 'one team' and 'no borders' cultural change
Increase skills mix through training and recruitment
Engagement
Create internal comms & engagement plan
Start internal comms & engagement
Create public engagement plan
Start public engagement
Design public consultation
Execute & analyse public consultation (subject to purdah)
Continue public comms & engagement
Launch event. Ongoing public comms
Continue workforce comms & engagement
Programme & PMO
Agree place-based programme plan for Year 2+3 in detail
Mobilise programme team
Define & mobilise programme transformation governance
Support local delivery to programme plan
Link with overall STP enabler workstreams
Assure delivery of above to plan
Manage risks, issues, programme budget, stakeholder engagement, programme governance
Milestones
Service Scope defined (01/01)
CSESA Strategy
#MCPs defined
Public consultation complete
5 year MCP and acute contracts in place
Delegated budgets agreed
Programme team in place
CSESA 4 year plan
Shadow delegated budgets agreed
MCPs live
Gateway* #1: Case for Change
Gateway #2a: Capabilities & contract set up (shadow)
Gateway #2b: Capabilities & contract set up (full MCP)
Gateway #3: Is it safe to commence?
* Gateways based on proposed Dudley CCG approach

What it will take to execute

Significant investment, time and thought will be needed to bring about this change

Investment in primary care is absolutely essential to the success of changing the system. Our GPs will provide clinical leadership, and they are at the heart of care hubs – our engines for delivery.

Investment

- **Investment** in all of the items listed here is needed, starting with **primary care**
- A **ring-fenced, pooled budget** used to fund all the above activity and the associated costs of delivery
- Tight, **centralised financial management** of budgets

Contracting

- An **outcomes framework** aligned with the national MCP contract and an agreement on **a risk/gain share** approach
- An framework for establishing **delegated budgets** to support shadow contracting, with a view to identifying early pilot delegated budgets e.g. in PCH vanguard

Leadership Development

- **Clinical leaders championing the change**, and working directly with peers to drive engagement across primary, community, secondary, tertiary, mental health, nursing, hospice, ambulance, pharmacy and other experts
- **Co-production** of service redesign engaging both workforce and patients – a coal-face integrated approach to implementing change, enabled by senior management delegation of local decision making
- Creating the **right forums and environment** to accelerate clinical dialogue at all levels – from care hubs through MCP up to governance forums – to **cut across organisational boundaries** and foster true joint working
- Continuous **clinical and patient/carer input** into service design
- **Leadership academy** to be ready in next academic year

Workforce

- Initial informal agreement to **pool workforce** where practical, via loans or secondments. Requires a **willingness to work across organisational boundaries**. **Workforce planning** needs to be performed across the **whole system**.
- Rapidly developed **training curriculum** to support Collaborative Care and Support Planning and enable us to grow the right type of resources. **Education** to upskill existing resources. This is needed to underpin both clinician and patient activation.
- **Place-wide contracts** for resource types across a variety of roles (e.g. paramedic practitioners, advance nurse practitioners)

Technology

- A fully developed **roadmap of delivery** for an **integrated digital care record**, including interim improvements to enable care hubs to operate at local scale
- **Clinical and patient/carer input** into solution design and testing
- Properly resourced **implementation team**

Estates

- **Pooling of estates** resources across the place into a single asset register, aligned with One Public Estate and combined ETTF bids
- Creation of additional space; repair, repurposing or disposal of existing space
- Use of estates for building **housing for key workers**
- **Consolidation** of estates management functions

Change Management

- A **dedicated function** for enabling the workforce, patients and public to absorb the changes
- An agreed change model for the **whole health and care system**
- A detailed and robust **comms and engagement** plan, backed up by the resources to execute it
- A new **operating and governance model**

Programme delivery

- A **single programme** plan run by a senior programme director, backed up by a team of clinical and commissioner experts, seconded subject matter experts and a lean PMO function
- Leveraging of **local care hub leadership** to deliver services within the programme timescale. Learning from local **vanguard PCH** projects.
- **Sponsorship** at the highest level and recognition that this is the single highest priority

Assumptions driving our financial model

There are a number of different levers that could be pulled in the acute setting to close the forecast financial deficit. The finance subgroup will model the impact of these levers to propose an optimal model that is both deliverable and maximises the potential savings.

Lever	Definition	Reduction assumption (worst case)	Max. saving	% saving	Cost of alternative…	…based on
Frailty	Any non elective admission for a patient over 75, with LOS <7 days	The SASH frailty business case assumes a Frailty Centre to provide a multidisciplinary approach to reducing frailty admissions; this could be implemented across all sites.	£21.2m	40%	£884 per avoided spell	Cost per patient in SASH Pendleton Assessment Unit (PAU) business case
Elective Reduction	Any elective, day case or outpatient activity	Based on the High Weald MSK approach, some electives will move to day case cost, day cases to out patient cost and out patient to community.	£296.4m	15%	£981 per avoided elective £450 per avoided day case £40 per avoided outpatient appt.	£981: average day case cost across the 5 CCGs. £450: average outpatient plus two follow-up appointments across the 5 CCGs £40: combined experience of the 5 CCG Directors of Finance.
Step Down Care	Excess bed days consumed by patients over 75	Excess bed days could be replaced in an alternative setting	£8.1m	50%	£200 per bed day saved	Real costs of a recent project in Brighton & Hove
Non Elective admission	Non elective stays of 0-1 days, excl. maternity	Many of these short stays could be avoided at using ambulatory care at a cost of £320	£17.4m	30%	£320 per avoided spell	Sample tariff from another acute trust
A&E	All Type 1 A&E activity, excl. UCC	These could be delivered in a UTC setting	£14.6m	30%	£90 per avoided attendance	Apportioned cost per patient of the existing block contract for the 24/7 UTC in Crawley
First Outpatient Appts.	All first OP appointments	Encouraging GPs to review whether appointment is necessary, potentially using peer review	£47.4m	5%	£60 per avoided appointment	Combined experience of the 5 CCG Directors of Finance
Long Term Conditions	*As per CCG Docobo risk stratification definition*	Enabling and supporting patients to self manage their long term conditions, thereby avoiding the patient getting critical enough to need hospital treatment	£1.2m	30%	£455 per avoided admission	Horsham and Mid Sussex tailored healthcare approach pilot
Complex Patients	*As per CCG Docobo risk stratification definition*	Care coordination and multi-disciplinary teams based in the community	£17.3m	30%	£719 per avoided admission	Annual running costs of admission avoidance schemes per admission avoided
PBR Excluded Drugs	All spend associated with PBR-X drugs	Medicine Management at pharmacy undertaking more drug reviews on non PBR drugs	£56.1m	20%	£0	Change in process using existing Medicines Management resources and tools

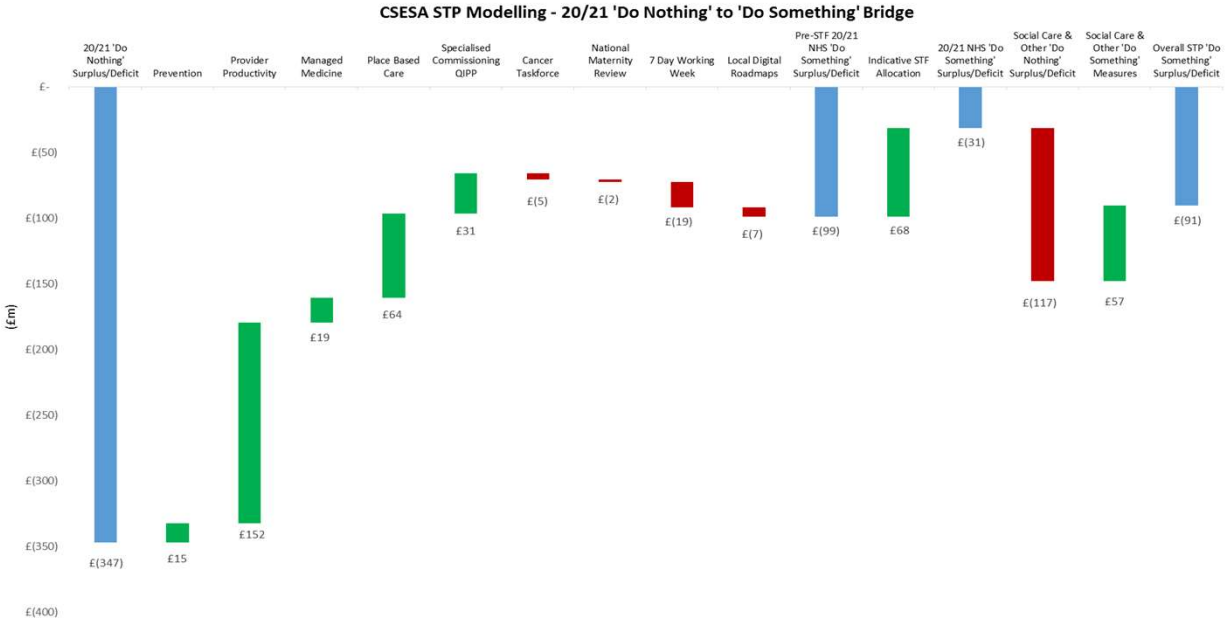
The model then de-duplicates savings by applying business logic to historical per-person data. It also assumes a benefits lag. After these adjustments the expected annual saving is:

Total annual saving expected at the end of year 5	£92m

← Indicative estimate that that there are sufficient savings available

Finance projection

By 2021 we expect to have addressed the financial gap – and improved quality and performance



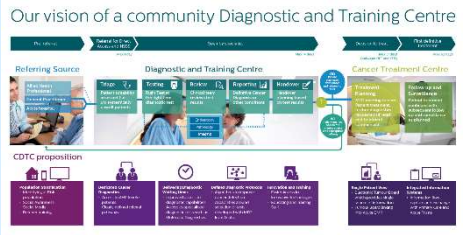
By Year 5 we will have reduced the healthcare deficit to £31m

- The current level of modelling performed indicates that there is sufficient total benefit (within the nine levers identified in our assumptions) to reduce the acute costs by 25% while being re-provided in the community at 70%; or cheaper. This is equivalent to a net saving of 7.5%.
- At this stage, the model does not take into account the one-off or ongoing investments in primary care that will be needed to enable this change to happen.
- We will undertake a more detailed modelling exercise between now and the end of March 2017. This will be done in parallel with a programme planning exercise so that firm dates can be put against benefits and costs.
- This doesn't take into account the quality and performance improvements that we expect the new model of care to bring, or the sustainable system that it will create.

- Further detailed modelling can examine whether increasing capacity out of hospital will lead to a direct corresponding reduction in bed capacity in acute. There are two reasons why this may not be the case:
  1. The immediate impact of reducing demand will be to enable the hospitals to remain safe at all times, even through winter resilience pressures
  2. A secondary impact will be to create the headroom for hospitals to absorb the additional – appropriate – demand that will occur with the demographic changes in the population, without having to open additional wards

We are assuming it will be possible for early wins to bring benefit in Year 2

- Our current model assumes a linear ramp-up of benefits over four years, starting in Year 2. This means that we expect 25% of benefits to have kicked in by March 2018. The model does not at this point specify the projects that will deliver this 25% of benefits in year 2.
- By the end of this financial year we will have drafted tailored logic models for each of the 20 care hubs in the CSESA place. These will help us to identify where to target early wins in each locality and across the place. However, there are projects that we aim to see delivering substantial benefits by the end of Year 2, for instance:
  1. We are currently exploring how to stand up one or more community diagnostic and training centres. These would supply X-ray, CT, MRI, ultrasound, bone scan and barium swallow services and address both the immediate shortfall in equipment and staffing capacity as well as the projected demand. This will significantly improve early diagnosis rates and RTT for cancer and other acute, chronic and long term conditions, which in turn will improve patient outcomes.



  2. Risk stratification will identify interventions needed for the top 2-5% of patients with long term conditions. Locality MDTs, widespread care coordination and efforts to increase patient activation can be put in place quickly to reduce the spend on the most costly percentiles whilst improving the quality of their care.

Governance

An adjusted governance model will be needed to oversee this period of transformation

- To launch the **integrated system** that our vision sets out, correct **governance is essential** to have decisions made by the groups with the appropriate legal authority to do so.
- Decisions need to be **binding**, made at the **right level** and the **right pace**. This will require clear roles and responsibilities, with engagement from the right stakeholders in the right forums at the right time.
- Moving to a single health and social care governance model across 5 CCGs and 4 local authorities will be a **complex task** and will take time to negotiate. This design and deployment work will be undertaken by the Change workstream of the programme and therefore an end-state solution is not set out here.
- In this submission, we define instead a proposed model of **governance** to **oversee the programme** and the **transition** to a new model. This is based on a set of **guiding principles**

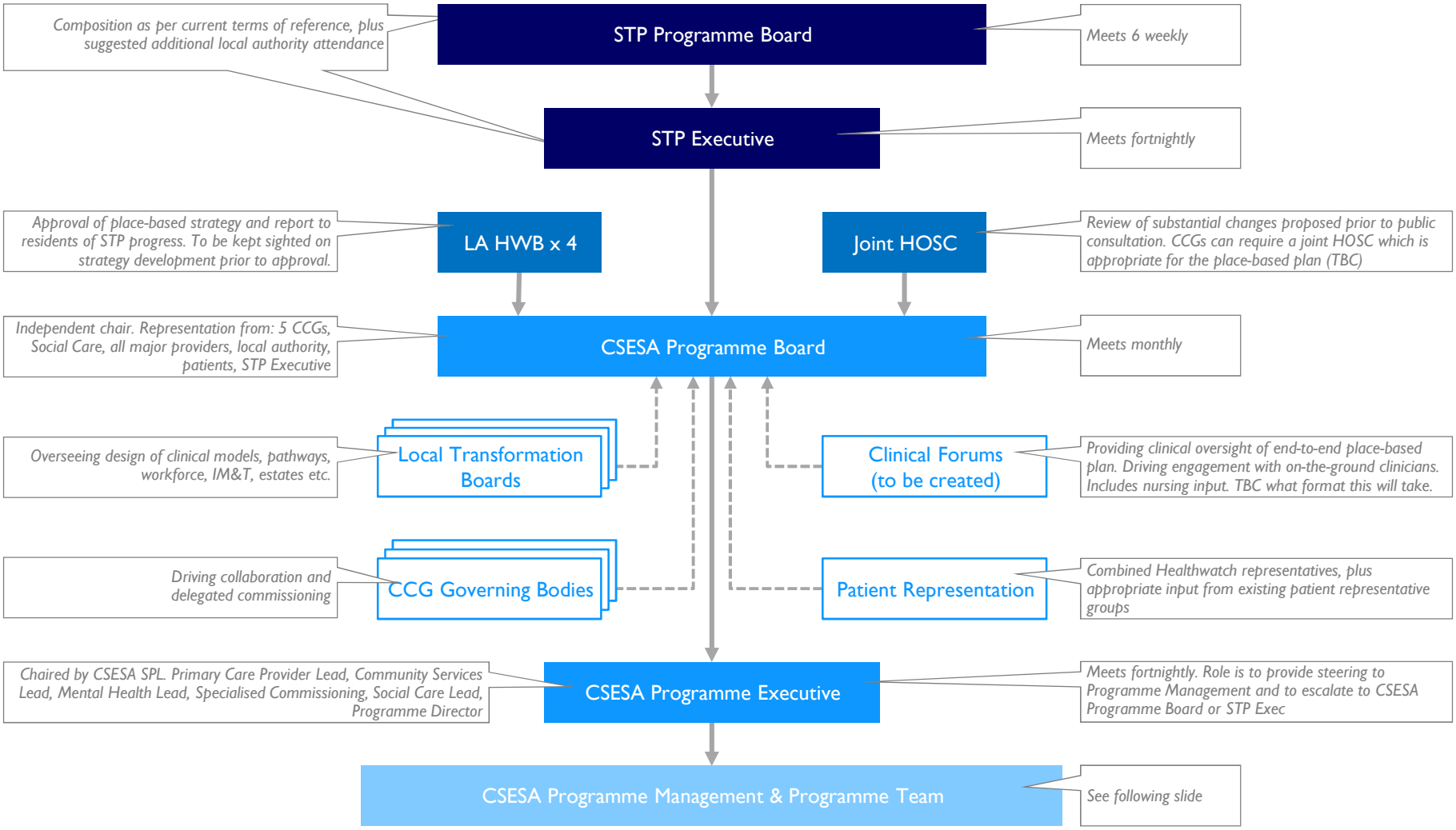
- Note that A common case for change, a common set of principles, a common MCP approach and common governance will not necessarily result in a singular outcome in terms of organisational form or local delivery model

Principles of Governance

- ✓ *Shared leadership*
- ✓ *Parity between board members*
- ✓ *Representation of all major providers*
- ✓ *Shared ownership of the board and accountability to communities*
- ✓ *Openness, transparency, inclusiveness*
- ✓ *Joined up governance to avoid repetition*
- ✓ *Programme board independent chair*
- ✓ *Democratic representation to provide public accountability*
- ✓ *The public will be engaged throughout and consulted appropriately*
- ✓ *Place-based programme aligns strategic direction across 'place'*
- ✓ *Seeks integration, sharing and efficiencies across place-based themes*
- ✓ *Works with the leadership of the other two places to align across borders and avoid repetition or competition*
- ✓ *Delivers consistent messages to STP Programme Board & individual organisations sovereign governance arrangements*
- ✓ *Delivers place-based messages alongside local strategy to the 4 HWB's to enable an aligned strategic view across the whole of the local health and care economy*
- ✓ *Local HOSCs continue to review proposals for substantial change in context of place based plans*
- ✓ *Single financial statements*
- ✓ *Single published view of estates*

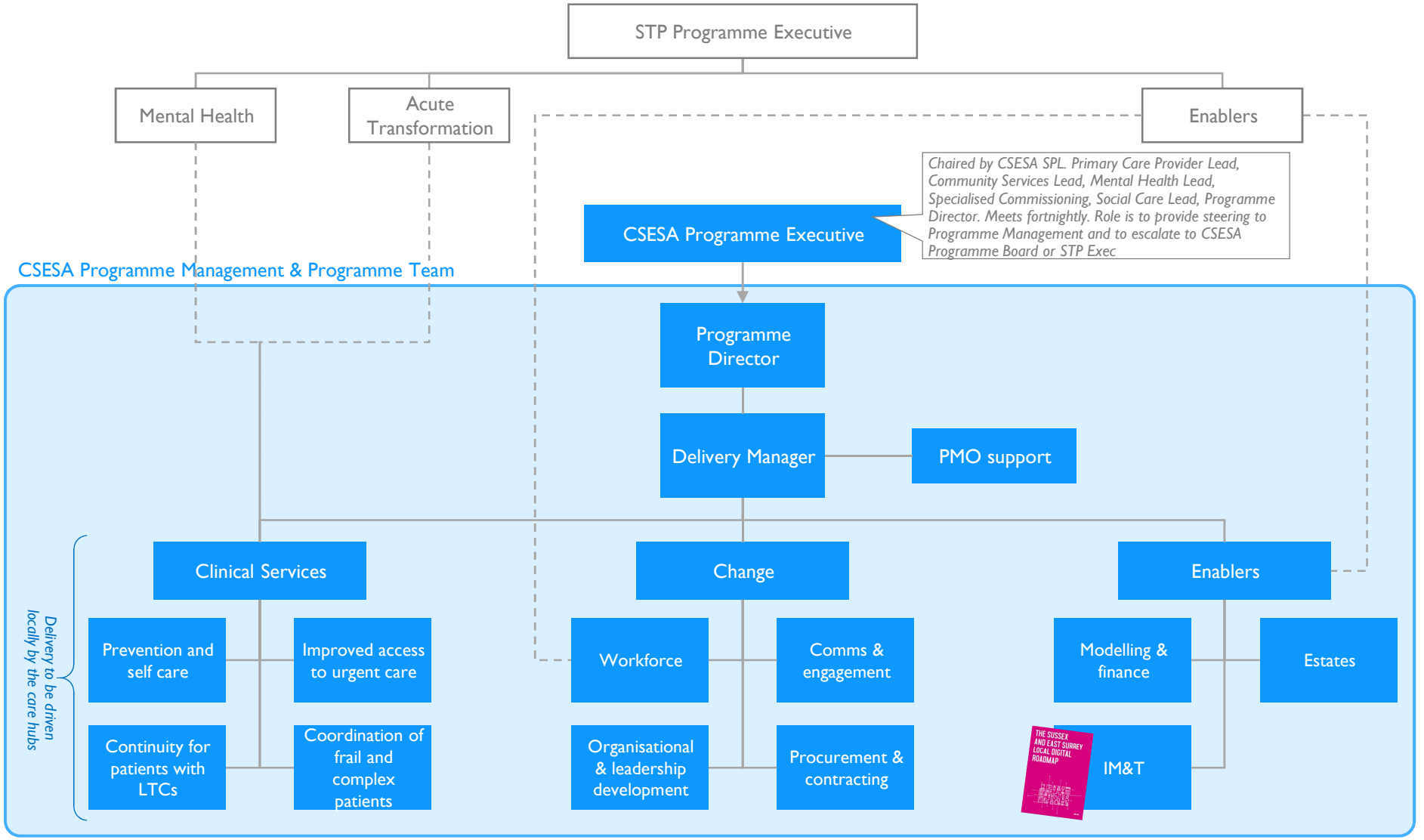
Programme and transition governance model

The **governance** here is that needed to oversee the **journey**, not the end state



Delivery programme structure

A robust, dedicated **programme team** to **deliver** the plan



In conclusion

The Central Sussex and East Surrey Alliance has a strongly held vision in common and we are already moving in the same direction

- We will transform our model of care: from one that is reactive, often crisis-triggered and heavily acute-focused – to one that promotes wellbeing, provides early detection and diagnosis and empowers people to manage their health more effectively within their communities. Primary care will lead the delivery of an effective and sustainable new care model. Practices will work in a more co-ordinated way with each other around natural geographies, embracing a wider skill mix. They will integrate with community health, mental health, social care and voluntary services.
- Each of the five CCGs have already established their respective care hubs. All 20 care hubs are in the process of integrating care around their local populations. We are also beginning to evidence the impact of more proactive, community-based care on utilisation of acute care - albeit in a narrow cohort of patients or geographical patch. Working together across the CSESA footprint, we will drive a level of efficiency, scale and pace for our clinical redesign programmes and organisational development. As we move to our MCP model we will consolidate pathways into and out of our acute providers more effectively. We will also have greater impact by working together on key enablers such as workforce requirements, interoperable digital care records and estates.
- We have set out an ambitious programme to realise fully operational, legal MCP entities by 2020. This will be underpinned by robust benefits realisation of the new care models, delegated population based budgets and reform of the commissioner landscape.
- We will now actively engage more fully with patients, clinicians, our public and key stakeholders, and in particular our local authority colleagues.
- We have a credible vision, a defined care model, clear timelines, demonstrable work in progress and a good understanding of our financial case. This puts us in a strong position to register an expression of interest for the next wave of vanguard funding.

Appendix A

Financial Modelling

Modelling Approach

Identify Opportunities	We have identified a number of activity groups that could potentially be moved out from the Acute setting. Each of the activity groups have been linked to discrete episodes with SUS data to enable us to understand the scope in terms of spells, bed days and tariff.
Build SUS Forecast Model	We have developed a sophisticated model that extrapolates historical SUS data into the future, using granular population growth data and historical trends.
Set Assumptions	Against each opportunity, we have identified the size of the opportunity, the extent to which Acute activity could be reduced and what it would cost to either reduce or re-provision the activity in a community / primary care setting.
Apply Assumptions to Model	The "before" and "after" SUS forecasts are compared to understand the impact of the opportunities in terms of bed days, spells and total spend.

We have identified 9 opportunity areas

Lever	Definition
Frailty	Any non elective admission for a patient over 75, with LOS <7 days
Elective Reduction	Any elective, day case or outpatient activity
Step Down Care	Excess bed days consumed by patients over 75

Lever	Definition
Non Elective admission	Non elective stays of 0-1 days, excl. maternity
A&E	All Type 1 A&E activity, excl. UCC
First Outpatient Appts.	All first OP appointments

Lever	Definition
Long Term Conditions	As per CCG Docobo risk stratification definition
Complex Patients	As per CCG Docobo risk stratification definition
PBR Excluded Drugs	All spend associated with PBR-X drugs

We have built a sophisticated model

Our model extrapolates out episode-level SUS data out to 2020

Demographic Growth and Demographic Change

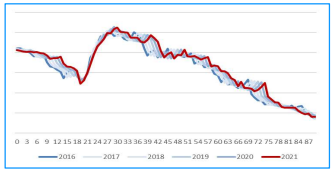
- Using granular ONS population data, we have extrapolated out episode-level FY2015/16 SUS data out to FY2020/21. This equates to 4,000,000 rows of data in the model, and is built on MS SQL-Server.
  - For example, if a CCG has an aging population, then the demand for services that the elderly will consume will grow at a faster rate than other services.
  - Similarly, as the elderly tend to have longer lengths of stay, the bed day demand will also increase.

Non Demographic Growth

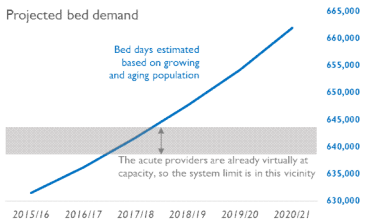
- Patient's expectations are increasing, as are advances in medical treatment. This has lead to longer term trends in activity that are, in many cases, over and above the demographic change.
- We have applied 3-year growth trends at POD / CCG level to the data.

Activity x Population Growth by Year and age band x 3yr historical Trend = Future Demand

Age	Gender	Specialty	HRG	Cost
0	M	560	PA57Z	£1,088
37	F	560	PB03Z	£981
68	M	560	PB03Z	£1,088
52	M	501	NZ08C	£1,088



CCG	POD	3 Yr. Trend
09D	A&E	2.05%
09D	DC	0.67%
09D	EL	2.90%
09D	NEL	-1.21%
09D	NELNE	-1.21%
09D	NELSD	-1.21%
09D	NELST	-1.21%
09D	OP	3.60%



We set the levels for our assumptions

The Directors of Finance for the 5 CCGs agreed the levels of saving and the cost of the alternative

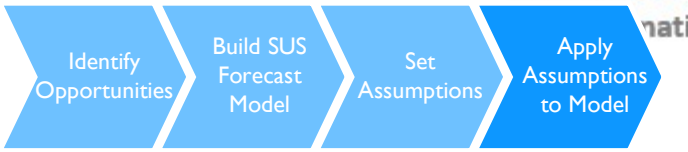
Lever	Definition	Reduction assumption (worst case)	Max. saving	% saving	Cost of alternative…	…based on
Frailty	Any non elective admission for a patient over 75, with LOS <7 days	The SASH frailty business case assumes a Frailty Centre to provide a multidisciplinary approach to reducing frailty admissions; this could be implemented across all sites.	£21.2m	40%	£884 per avoided spell	Cost per patient in SASH Pendleton Assessment Unit (PAU) business case
Elective Reduction	Any elective, day case or outpatient activity	Based on the High Weald MSK approach, some electives will move to day case cost, day cases to out patient cost and out patient to community.	£296.4m	15%	£981 per avoided elective £450 per avoided day case £40 per avoided outpatient appt.	£981: average day case cost across the 5 CCGs. £450: average outpatient plus two follow-up appointments across the 5 CCGs £40: combined experience of the 5 CCG Directors of Finance.
Step Down Care	Excess bed days consumed by patients over 75	Excess bed days could be replaced in an alternative setting	£8.1m	50%	£200 per bed day saved	Real costs of a recent project in Brighton & Hove
Non Elective admission	Non elective stays of 0-1 days, excl. maternity	Many of these short stays could be avoided at using ambulatory care at a cost of £320	£17.4m	30%	£320 per avoided spell	Sample tariff from another acute trust
A&E	All Type 1 A&E activity, excl. UCC	These could be delivered in a UTC setting	£14.6m	30%	£90 per avoided attendance	Apportioned cost per patient of the existing block contract for the 24/7 UTC in Crawley
First Outpatient Appts.	All first OP appointments	Encouraging GPs to review whether appointment is necessary, potentially using peer review	£47.4m	5%	£60 per avoided appointment	Combined experience of the 5 CCG Directors of Finance
Long Term Conditions	*As per CCG Docobo risk stratification definition*	Enabling and supporting patients to self manage their long term conditions, thereby avoiding the patient getting critical enough to need hospital treatment	£1.2m	30%	£455 per avoided admission	Horsham and Mid Sussex tailored healthcare approach pilot
Complex Patients	*As per CCG Docobo risk stratification definition*	Care coordination and multi-disciplinary teams based in the community	£17.3m	30%	£719 per avoided admission	Annual running costs of admission avoidance schemes per admission avoided
PBR Excluded Drugs	All spend associated with PBR-X drugs	Medicine Management at pharmacy undertaking more drug reviews on non PBR drugs	£56.1m	20%	£0	Change in process using existing Medicines Management resources and tools

The model then de-duplicates savings by applying business logic to historical per-person data. It also assumes a benefits lag. After these adjustments the expected annual saving is:

Total annual saving expected at the end of year 5	£92m

← Indicative estimate that that there are sufficient savings available

The model enables users to test the impact of different assumptions



- The front end of the model is built in Excel (see following slide) and takes a summary feed from the SUS Forecast model.
- The summary feed totals activity and cost by a variety of dimensions including CCG, POD, Site, Year, and, importantly, allocates flags against the each row according to which opportunities the data applies to.
- Within the Excel model, we can assign multiple opportunities to each episode.
  - For example, a 75 year old non elective admission could be subject to multiple opportunities, but in reality that episode can only be saved once.
  - The model ensures that double counting is minimised by applying business logic to each episode; this ensures that for opportunities are that mutually exclusive, only the opportunity that has the greatest impact is applied.
- The CCGs and Providers can then apply different assumptions to the model, and instantly see the impact. These assumptions are:
  - Year-by-year scale to which Acute activity can be reduced by each opportunity
  - Unit cost of re-provisioning or avoiding Acute activity
- As the model is built up from granular data, it is possible to view the impact of the opportunities by multiple dimensions:
  - CCG, Site / Trust, POD etc…

A quick overview of the Excel model

1 Do Nothing view, aligned with 2020Delivery financial model

2 Opportunities, and extent to which activity could be reduced

3 Ramp-up profile of opportunities

4 View of Acute spend once opportunities have been implemented

5 Cost of reducing / re-provisioning each opportunity

6 Net impact to financial position

Do Nothing

	In Patient, Out Patient and A&E	Baseline	Do Nothing	-->	-->	-->
	CCG	2016	2017	2018	2019	2020
	NHS BRIGHTON & HOVE CCG	£ 120.8m	£ 122.3m	£ 123.6m	£ 124.9m	£ 127.5m
	NHS CRAWLEY CCG	£ 66.4m	£ 67.4m	£ 68.4m	£ 69.4m	£ 71.2m
	NHS EAST SURREY CCG	£ 96.0m	£ 96.1m	£ 96.1m	£ 96.2m	£ 97.3m
	NHS HORSHAM AND MID SUSSEX CC	£ 112.3m	£ 115.7m	£ 118.8m	£ 122.1m	£ 126.6m
	NHS HIGH WEALD LEWES HAVENS CC	£ 81.4m	£ 82.8m	£ 84.1m	£ 85.3m	£ 87.4m
	NON PBR DRUGS (CCG)	£ 19.2m	£ 20.1m	£ 21.0m	£ 22.0m	£ 23.2m
	OTHER ACUTE ACTIVITY	£ 53.4m	£ 59.8m	£ 67.2m	£ 74.2m	£ 81.2m
	ACUTE - NON NHS	£ 66.0m	£ 67.8m	£ 69.6m	£ 71.4m	£ 73.8m
SUS	SPECIALIST	£ 59.1m	£ 62.6m	£ 66.0m	£ 69.6m	£ 73.6m
Non SUS	SPECIALIST (Non SUS)	£ 165.3m	£ 178.1m	£ 192.4m	£ 207.7m	£ 225.8m
	NON PBR DRUGS (SpecComm)	£ 37.0m	£ 40.2m	£ 42.1m	£ 44.1m	£ 46.2m
	TOTAL	**£ 876.8m**	**£ 913.0m**	**£ 949.2m**	**£ 987.0m**	**£ 1,033.8m**

Do Something - based on Levers

	In Patient, Out Patient and A&E	Baseline	Do Something	-->	-->	-->
	CCG	2016	2017	2018	2019	2020
	NHS BRIGHTON & HOVE CCG	£ 120.8m	£ 119.0m	£ 116.9m	£ 114.7m	£ 113.5m
	NHS CRAWLEY CCG	£ 66.4m	£ 65.5m	£ 64.4m	£ 63.2m	£ 62.7m
	NHS EAST SURREY CCG	£ 96.0m	£ 93.4m	£ 90.6m	£ 87.8m	£ 85.9m
	NHS HORSHAM AND MID SUSSEX CC	£ 112.3m	£ 112.5m	£ 112.2m	£ 111.9m	£ 112.6m
	NHS HIGH WEALD LEWES HAVENS CC	£ 81.4m	£ 80.5m	£ 79.3m	£ 78.1m	£ 77.6m
	NON PBR DRUGS (CCG)	£ 19.2m	£ 19.1m	£ 18.9m	£ 18.7m	£ 18.6m
	OTHER ACUTE ACTIVITY	£ 53.4m	£ 59.8m	£ 67.2m	£ 74.2m	£ 81.2m
	ACUTE - NON NHS	£ 66.0m	£ 67.8m	£ 69.6m	£ 71.4m	£ 73.8m
SUS	SPECIALIST	£ 59.1m	£ 61.3m	£ 63.4m	£ 65.5m	£ 67.9m
Non SUS	SPECIALIST (Non SUS)	£ 165.3m	£ 178.1m	£ 192.4m	£ 207.7m	£ 225.8m
	NON PBR DRUGS (SpecComm)	£ 37.0m	£ 38.2m	£ 37.9m	£ 37.5m	£ 36.9m
	[Complex Patients]	£ - m	-£ 2.7m	-£ 5.6m	-£ 8.7m	-£ 11.9m
	TOTAL	**£ 876.8m**	**£ 892.5m**	**£ 907.2m**	**£ 922.2m**	**£ 944.6m**
	Acute Savings	**£ - m**	**-£ 20.5m**	**-£ 42.1m**	**-£ 64.8m**	**-£ 89.2m**

Assuming no savings
Assuming no savings
Assuming no savings
Complex patients are calculated separately, in lieu of Docabc data to merge with SUS

Prevention / Reprovisioning Costs

	Lever	2016	2017	2018	2019	2020
	Frailty	£ - m	£ 0.7m	£ 1.4m	£ 2.2m	£ 2.9m
EL	Elective Reduction	£ - m	£ 0.6m	£ 1.2m	£ 1.9m	£ 2.6m
DC	Elective Reduction	£ - m	£ 1.1m	£ 2.2m	£ 3.4m	£ 4.5m
OP	Elective Reduction	£ - m	£ 1.1m	£ 2.3m	£ 3.5m	£ 4.9m
	Step Down Care	£ - m	£ 0.7m	£ 1.3m	£ 2.0m	£ 2.7m
	Non Elective Admission	£ - m	£ 0.5m	£ 0.9m	£ 1.4m	£ 1.9m
	A&E	£ - m	£ 2.0m	£ 4.0m	£ 6.2m	£ 8.4m
	First Outpatient Appointments	£ - m	£ - m	£ - m	£ - m	£ - m
	Long Term Conditions	£ - m	£ 0.0m	£ 0.1m	£ 0.1m	£ 0.2m
	Complex Patients	£ - m	£ 0.7m	£ 1.5m	£ 2.3m	£ 3.2m
	PBR Excluded Drugs (CCG)	£ - m	£ - m	£ - m	£ - m	£ - m
	PBR Excluded Drugs (SpecComm)	£ - m	£ - m	£ - m	£ - m	£ - m
	TOTAL	**£ - m**	**£ 7.4m**	**£ 15.0m**	**£ 23.0m**	**£ 31.2m**
	Net Savings	**£ - m**	**-£ 13.2m**	**-£ 27.1m**	**-£ 41.9m**	**-£ 58.0m**
			Net Total (across all years)			**-£ 140.2m**

	Levers	Spend (2016)			2017	2018	2019	2020
2	Frailty	£ 19.3m	40%	*Patient is over 75, LOS <7, NEL*	10%	20%	30%	40%
3	Elective Reduction	£ 296.3m	10%	*PCD is EL, DC or Out Patient*	3%	5%	8%	10%
4	Step Down Care	£ 8.1m	50%	*Age >= 75, Excess Bed Days*	13%	25%	38%	50%
5	Non Elective Admission	£ 19.7m	30%	*NEL, LOS <=1*	8%	15%	23%	30%
6	A&E	£ 26.2m	30%	*HRG in VER07Z, VER08Z, VER09Z, VER11Z, no*	8%	15%	23%	30%
7	First Outpatient Appointments	£ 47.4m	5%	*First OP*	1%	3%	4%	5%
8	Long Term Conditions	£ 2.9m	50%	*HRG in Diabetes, Pulmonary, Arthritis or*	13%	25%	38%	50%
9	Complex Patients	£ 35.6m	30%	*Previous CCG analysis (see tab)*	8%	15%	23%	30%
10	PBR Excluded Drugs (CCG)	£ 19.2m	20%		5%	10%	15%	20%
11	PBR Excluded Drugs (SpecComm)	£ 37.0m	20%		5%	10%	15%	20%

Levers		Unit Costs	
Frailty		£ 884	*per admission reduced*
Elective Reduction	EL	£ 981	*per elective reduced*
"	DC	£ 450	*per day case reduced*
"	OP	£ 40	*per out patient appointment saved*
Step Down Care		£ 150	*per excess bed day saved*
Non Elective Admission		£ 320	*per admission reduced*
A&E		£ 90	*per attendance saved*
First Outpatient Appointments		£ 40	*per attendance saved*
Long Term Conditions		£ 204	*per admission reduced*
Complex Patients		£ 884	*per admission reduced*
PBR Excluded Drugs (CCG)		£ -	*per £ saved*
PBR Excluded Drugs (SpecComm)		£ -	*per £ saved*

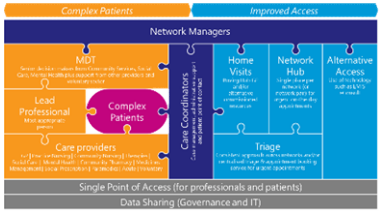
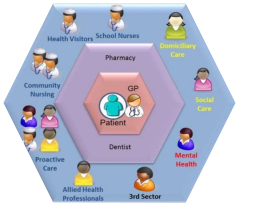
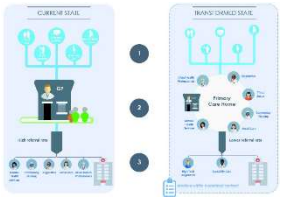
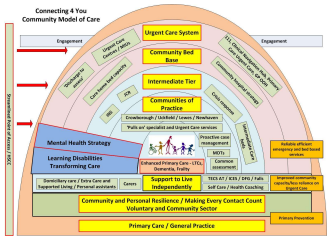
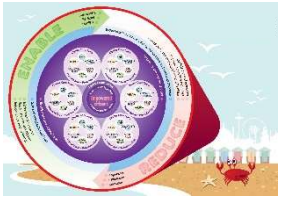
Levers	
Frailty	*Based on SASH bus case*
Elective Reduction	*Avg cost of Day Case*
"	*Avg cost of OP1 + 2xOP2*
"	*Estimate*
Step Down Care	*Estimate*
Non Elective Admission	*Based on OP1 cost*
A&E	*Based on Crawley average*
First Outpatient Appointments	*Estimate*
Long Term Conditions	*Self care*
Complex Patients	*Specialist unit*
PBR Excluded Drugs (CCG)	*Estimate*
PBR Excluded Drugs (SpecComm)	*Estimate*

Appendix B

Existing primary care development projects

How each CCG is currently developing primary care

All 5 CCGs are already taking steps to integrate primary care at scale

CCG	# Care Hubs / practices	Development Project Name	Current status summary	Model
East Surrey	4 Networks / 18 general practices	Primary Care Networks	There is a GP Federation – Alliance for Better Care Ltd – representing all practices which has worked with the CCG and other partners to co-develop new models of care that can be used to both drive the establishment of the networks and improve access to urgent care and the coordination of the most complex patients, including integrated models with social care, mental health and community services. The CCG has awarded a preferred provider contract to the federation for enhanced primary services, and is now determining how best to invest in the new model.	
Crawley	2 Communities of Practice / 12 general practices	Communities of Practice	In 2016/17 the CCGs are jointly developing enhanced primary healthcare teams, bringing together community nursing teams and multi-disciplinary proactive care teams into one integrated team based around communities of practice in the communities. Care will be designed around complex patients supported by the enhanced multidisciplinary teams and focused on early intervention, living well at home and avoiding unnecessary use of the hospital with specialist care in the community. They will test and widen new skills and roles for enhanced primary care teams, including for example increased use of pharmacists, community paramedics and advanced nurse practitioners. They will work more closely with the third sector. There will be a much stronger focus on empowering and supporting patients and their carers, to give them the knowledge, skills and confidence to manage their own condition. In East Grinstead, HMS CCG are running a vanguard pilot of the Primary Care Home model.	
Horsham and Mid Sussex	4 Communities of Practice / 23 general practices	Communities of Practice & Primary Care Home (PCH)		
High Weald Lewes Havens	4 Communities of Practice / 20 general practices	Connecting 4 you	Established four localities to develop 'Communities of Practice' to deliver integrated primary, community and urgent care services. Developing networks in the four localities to identify and deliver bespoke and agreed local priorities to improve primary care sustainability, access and outcomes. Launching the redesigned MSK, diabetes and dementia pathways, and OOH / urgent care plans. Improving care for the frail elderly and vulnerable population. A review of the services provided in primary care for people with learning disabilities. Further developing pathways for standardised approach to LTCs. Provision of responsive and children's services. High Weald is part of a pioneer site for maternity choice	
Brighton & Hove	6 Clusters / 44 General practices	Brighton & Hove Caring Together	B&H CCG have moved 5,000 patient pathways per year from hospital to community and primary care settings and contained growth in demand for hospital services - over the past five years A&E attendance has remained stable and emergency hospital admissions have decreased. To do this, they grew our crisis response services and run award-winning public communications campaigns. They use risk stratification, deliver proactive care through the clusters, deploy care coaches and health trainers and launched 'My Life' website.	

Appendix C

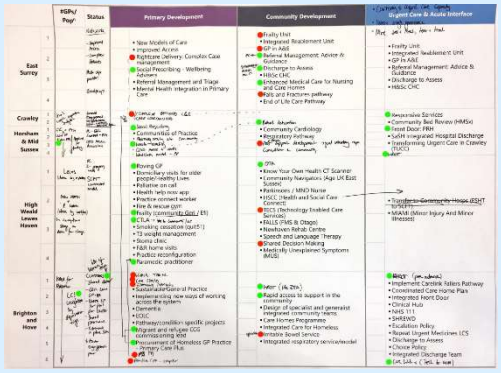
Parties involved in developing this plan

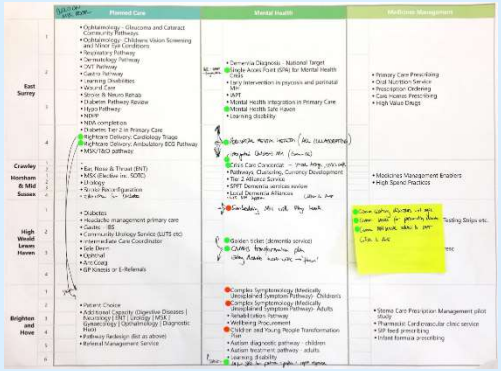
Workshops

Most content was generated through three workshops. Remaining content was established through a mixture of one-to-one conversation, and frequent review of iterated document drafts by all parties.

CCG integration leads

- Directors worked together to identify which projects and plans from each CCG could be easily shared and re-used across the place – and which areas of development needed collaborative thinking



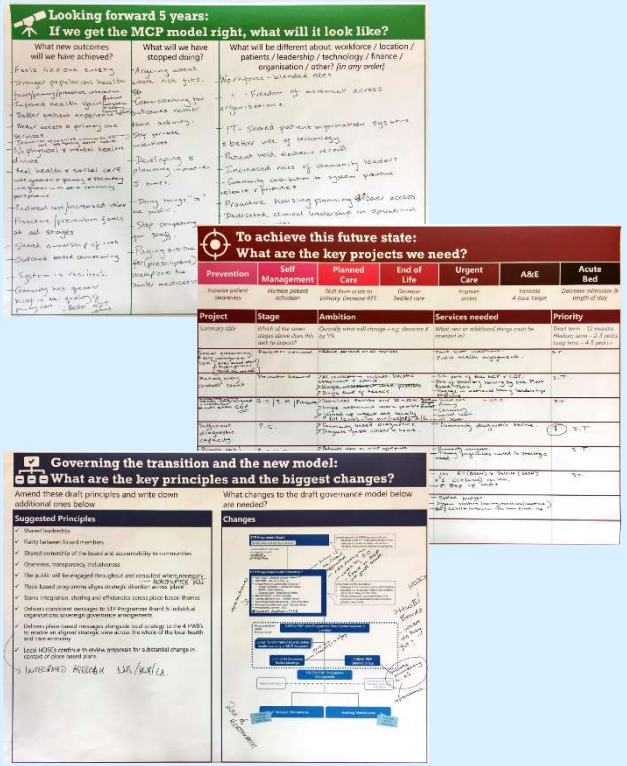


Providers

- Leaders of the following organisations worked on the place's vision, priority projects and governance
- **CCGs**: All 5
- **General practice**: ABC (East Surrey GP federation)
- **Acute**: Surrey and Sussex Healthcare, Queen Victoria Hospital, Brighton and Sussex University Hospitals
- **Community health**: First Community Health Care, Sussex Community Foundation Trust
- **Mental health**: Surrey and Borders Partnership, Sussex Partnership
- **Paramedic services**: SECAmb
- **Local authority**: West Sussex County Council, East Sussex County Council, Brighton and Hove County Council
- **Health education**: Kent, Surrey & Sussex Leadership Collaborative
- **Patients**: Healthwatch Surrey, Brighton & Hove

GPs

- A group of GPs and practice managers drawing from CCG clinical chairs, CCG clinical leads, GP federations and interested GPs discussed an early draft of the place based plan; and what it will take to drive engagement from primary care in this change



East Sussex Better Together Place-Based Delivery Plan

FOR SUPPORTING MATERIALS, PLEASE SEE ESBT WEBSITE:

https://news.eastsussex.gov.uk/east-sussex-better-together/

Background information

Introduction to East Sussex:

- East Sussex has a population of 539,800 residents (mid-2014 estimates), this has increased by 7% over the last ten years. It has an older age profile compared to England and Wales (25% of the population is currently aged over 65 compared to 18% nationally), this is being compounded by a net inflow of migration of older people into the county
- Between 2014 and 2027 the total population is predicted to grow by 5.5%, with the over 65 group alone growing by 27%. Overall the health of people in East Sussex is better than the average for England. This however masks significant variations in health outcomes across the county:
  - life expectancy between adults living in affluent and socially deprived areas within the county vary (7.3 years for men, 6.7 years for women)
  - there are significant variations in health outcomes amongst children as a result of income deprivation (28% of children in Hastings live in households that are economically deprived)
- The proportion of people living with long term conditions (LTCs), such as diabetes and heart disease, has increased and is contributing to significant pressures on health and social care services
- By 2021 it is projected that 22% of the population in East Sussex will be living with a LTC. People with LTCs account for 50% of all GP appointments, 64% of outpatient appointments, 70% of all inpatient bed days and consume 70% of the total health and care spend, signifying a significant demand on health and social care services
- Formed in 2014, **East Sussex Better Together** (ESBT) is our local response to these challenges – originally a partnership between East Sussex County Council (ESCC), Eastbourne, Hailsham & Seaford CCG and Hastings & Rother CCG. The partnership now formally includes our two major providers, East Sussex Healthcare Trust (ESHT) and Sussex Partnership Foundation Trust (SPFT)

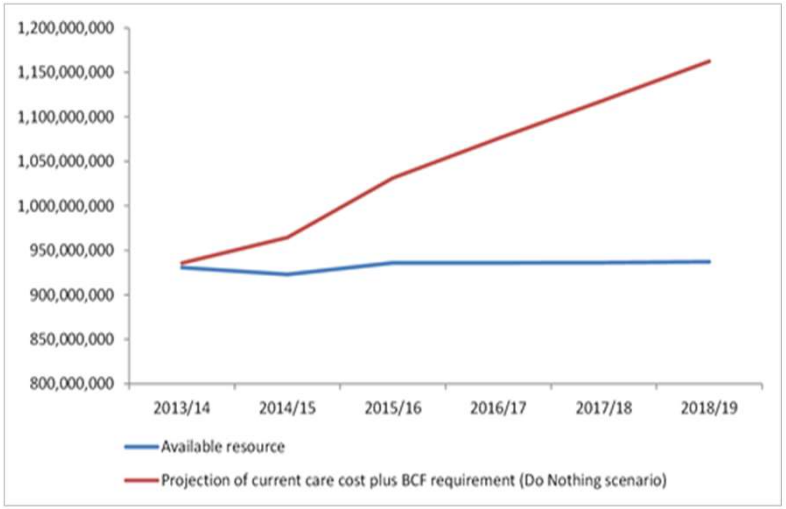
Case for change:

ESBT has recognised since 2014 that the health and social care systems within East Sussex are under significant pressure and face the following challenges:

- **Population health and wellbeing** – the population in East Sussex is aging, with increasing need for long term care and support. The numbers of people with long term conditions is also increasing. There are also significant health inequalities and outcomes across the county.
- **Quality and safety** – there are clinical and financial sustainability challenges across our two hospitals and social care which impact on the quality and safety of care. Primary care services are also under pressure to manage increasing demand for health and care services. Pressure also exists within the local social care market to provide services of the quality expected to help people remain independent.
- **Affordability** – overall the health and social care system within East Sussex is not affordable within the way it is currently organised. If services continue to be delivered in the same way, it is predicted there will be a funding gap of £253million by 2021 (commissioners £134 million, Providers £119 million).

For more information on the ESBT programme and its evidence base, please visit: http://news.eastsussex.gov.uk/east-sussex-better-together/

Do nothing scenario:



Vision and Governance

East Sussex Better Together (ESBT):

ESBT is our 150 week whole system health and care transformation programme, and was formally launched on 1st August 2014 in recognition that the current pressures on health and social care provision in East Sussex will not disappear and leaving the system 'as it is' was no longer an option. Taken together, the challenges outlined above need a whole system, multi-agency and innovative response. ESBT (formed as a partnership between ESCC, Eastbourne, Hailsham & Seaford CCG and Hastings & Rother CCG initially but now including East Sussex Healthcare Trust (ESHT) and Sussex Partnership Foundation Trust (SPFT) (our two major providers)) is our local response to these challenges. Its aim is to transform the way health and social care is provided locally through the development of fully integrated services, greater emphasis on disease prevention and increasing community based health and social care solutions. It is envisioned that people can be kept well for longer at home and so reduce reliance on expensive bedded care options both in the residential and acute sectors. This will involve integrated solutions and partnership working all sectors of health and social care (including primary care, community and acute service providers, as well as social care, mental health independent and voluntary organisations).

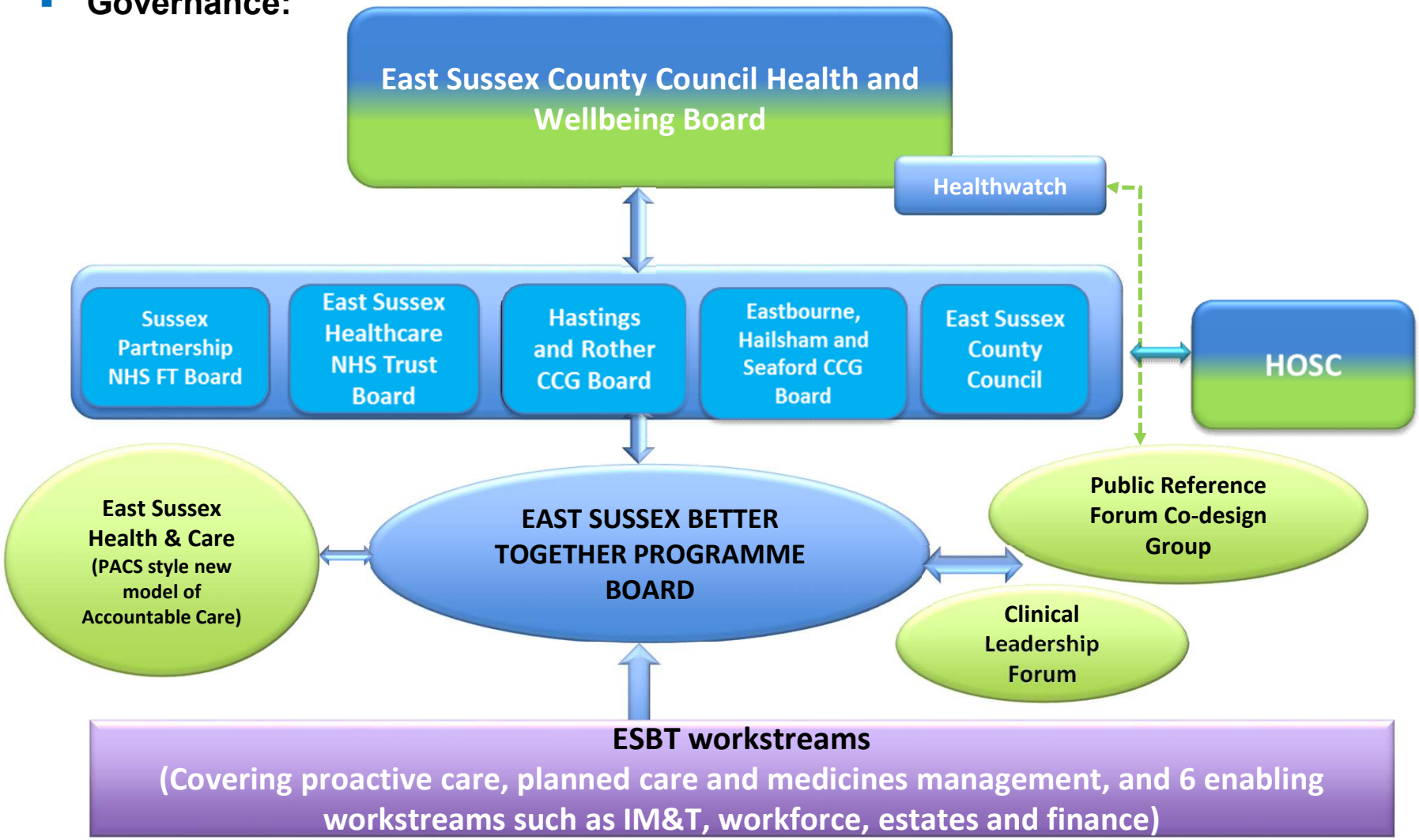
Vision:

- Since 2014 we have been working to achieve our shared vision of a fully integrated health and social care economy in East Sussex that makes sure people will receive proactive, joined up care, supporting them to live as independently as possible and achieving the best possible outcomes.
- In our vision of whole system integrated care all health and social care services, including primary and acute, work together to create innovative ways to deliver high quality person-centred care, to empower and support people to maintain independence and to lead full lives as active participants in their community.
- To achieve this we developed a framework known as the 6 plus 2 box model of care. The six boxes describe the services and support required throughout the whole cycle of an individual's care and support – from prevention through to bedded care, mental and physical health, primary and secondary services. Two further boxes are additional areas where we want to improve the quality and affordability of services.

- Achieving our vision of whole system integrated care in East Sussex will mean reshaping the way care is provided, bringing health and social care together in order to improve the quality and experience of care for individuals, the outcomes we achieve, and ensuring financial sustainability for the system. Future state modelling of anticipated activity levels across all sectors to achieve the transformation is currently being undertaken. We are finalising our plans for developing a local accountable care organisation to test in the ESBT footprint from 2017/18. The model envisaged will deliver sustainable provision across primary, community, acute, mental health and social care by 2020/21. Further information can be found at: http://news.eastsussex.gov.uk/east-sussex-better-together/whats-improving/care/

Vision and Governance

- **Governance:**



To learn more about our governance processes, please visit: http://news.eastsussex.gov.uk/east-sussex-better-together/stakeholders/

Vision and Governance

Programme Governance, Leadership & Resourcing:

- Initially set up in 2014 as a transformational programme, this has now evolved into a whole system partnership that includes everything and everybody employed by the partner organisations, and incorporates acute and primary care, adult's and children's social care and mental health. The partnership has evolved from being a partnership of commissioners to being complete whole system and includes our two major providers – East Sussex Healthcare Trust (ESHT) and Sussex Partnership Foundation Trust (SPFT).
- Building on the ESBT programme transformation work-streams, as we move to a business as usual position we are establishing strategic planning and delivery groups across the ESBT footprint. These groups are aligned to the 6+2 box model of care, or reflect specialist client groups. These will be responsible for delivering an integrated 5 year strategy and investment plan for their service areas.
- ESBT has strong system leadership across the partnership. The SROs of ESCC, the CCGs and ESHT operate as joint system leaders and are working closely with others and across sectors to deliver the required transformation. The SRO of ESCC represents the system as the SPOL for the STP, ensuring an integrated and complementary approach across the STP footprint and place-based plan, and ensuring benefits are realised across the footprint.
- ESBT has strong clinical leadership and engagement across the programme:
  - CCG Governing Bodies – 10 GPs are elected to represent the membership
  - ESBT Programme Board – representation at Board level from Governing Body Chairs, and appointed ESBT Clinical Director
  - ESBT Clinical Leadership Forum – recently formed, this brings together experts from locally employed medical workforce to act as primary resource for care pathway, service specific and medical workforce advice to the ESBT Board and constituent organisations. This includes designing the medical workforce which can best deliver both our local place-based Accountable Care model as well as the effective operation of acute clinical networks in the context of the wider STP work
  - ESBT Transformation Work-streams - clinical engagement and involvement with GPs as core activity; other clinical /professional leadership where appropriate
  - Practice Operational Forum & Membership Engagement & Learning Events (MELEs) – part of wider GP/primary care engagement

Organisational Development:

- ESBT has ensured system-wide senior leadership to create a partnership approach amongst provider stakeholder organisations to develop a Workforce Strategy. The strategy ensures we create the workforce needed to deliver the ambition of ESBT and the STP for Sussex and East Surrey and thereby meet the needs of our local population. A key enabler to delivering the ESBT Workforce Strategy is an overarching Organisational Development plan that is designed to enhance our system leadership; support system wide transformation to fully integrated health and care services; and deliver the accountable care model of delivery required to fully realise and sustain transformation.
- The plan does not replace constituent organisational plans but will operate at system and organisational level through a range of OD interventions, particularly in respect of leadership development, shared learning, and creating the permissions and accountability at all levels of the system to lever change. For example, interventions include:
  - develop understanding and knowledge of wider system through shared learning opportunities across organisations (e.g. sharing lunch and learn topics)
  - learning module that outlines what it means to be a systems leader (taught interactive 90 minute module)
  - develop a joint learning and development programme so that our staff across the ESBT footprint can learn together
  - provide opportunities for colleagues to connect across the system through innovative scheme (randomised coffee trials)
  - enhance characteristics of system leaders through bespoke learning events and development of systems OD toolkit (e.g. Toolkit which supports techniques such as appreciative inquiry and open dialogues)
  - co-design of our accountable care model, identifying development required and implementing plans
  - meaningful and relevant change management programmes that respond to the extent of change required
- The ESBT Workforce Strategy also prioritises the need to support building capacity and sustainability in Primary Care through several CCG supported initiatives articulated in our local Primary Care Workforce and sustainability plan. A Community Education Provider Network (CEPN) has been established across the ESBT footprint to promote and commission the right education and training for primary care staff, that will enable a sustainable and resilient primary care into the future; differently skilling staff; easing known pressures on GPs, and improving access for patients.

Progress to Date

Since our 150 week programme started in 2014, we have made good progress with work on the overall vision, pathways and redesign in the following areas:

Improving the health outcomes for populations:

- **Tackling health inequalities** – using combined resources to address differences in health inequalities and improve the health of those with the poorest outcomes. Targeting resources on specific geographical areas or groups who are known to have poorer outcomes. For example the Healthy Hastings Programme
- **Chances for Change** has been commissioned to improve the health of those most at risk of health inequalities, by using asset based approaches to develop and deliver health improvement opportunities and interventions at a local community level
- A **grants programme to support schools** to develop school health improvement plans and initiatives to improve health in the school setting has been offered to all schools in East Sussex
- We have funded new **Locality Link Worker** posts to help shape the way that health and social care teams support their clients to access community services and support, and help to shape the support that's available in communities.
- We're working with communities to support them to identify, strengthen and grow the resources and capabilities that exist within communities, groups or individuals to maintain and improve their health and wellbeing - **community resilience**
- We've supported over 7,000 people to maximise their health and wellbeing through our **Joint Community Rehabilitation** service. 77% of people have been helped to stay at home with no need for ongoing support

Enhancing the quality and experience of people's care:

- We have launched **Health and Social Care Connect -** a new phone and triage service that's helping people to receive care and support faster and ensure professionals can refer people to the right services at the right time
- We have also established a **single front door for referrals** for Children's social care and non-statutory early help, linked to Child and Adolescent Mental Health Services (CAMHS), so that referrals to CAMHS can be redirected, where possible without referrers needing to re-refer
- We have developed **6 integrated locality-based teams of health and social care professionals** with single line management in the Eastbourne, Hailsham and Seaford localities and in Hastings & Rother. For the first time local people's health and social care needs will be provided by one integrated team
- Locally commissioned services have been agreed for vulnerable adults in **Primary Care** to include avoiding unplanned admissions, advanced care planning and meeting palliative care needs
- We've launched the **Frailty Practitioner Service** to reduce the number of frail elderly people who are in hospital and whose care could be delivered more effectively in the community, and to avoid unnecessary admission to hospital altogether
- We have developed **Proactive Care** teams who are providing monitoring and support to patients identified within practices as being High Risk of developing acute need
- A **new urgent care service model** has been designed that includes the provision of new urgent care hubs at the front of emergency departments and extends access to community-based seven-day urgent care services
- We have launched a new **crisis response service** to prevent unnecessary hospital admission by providing urgent assessment and provision of community nursing care, in people's own homes. The service is made up of a team of Nurse Practitioners, Healthcare Assistants, Occupational Therapists, Physiotherapists and night sitters
- We have established a **Community Provider Education Network** (CEPN) to maximise the opportunities for joint education, training and development initiatives, with the initial focus on supporting sustainability in primary care

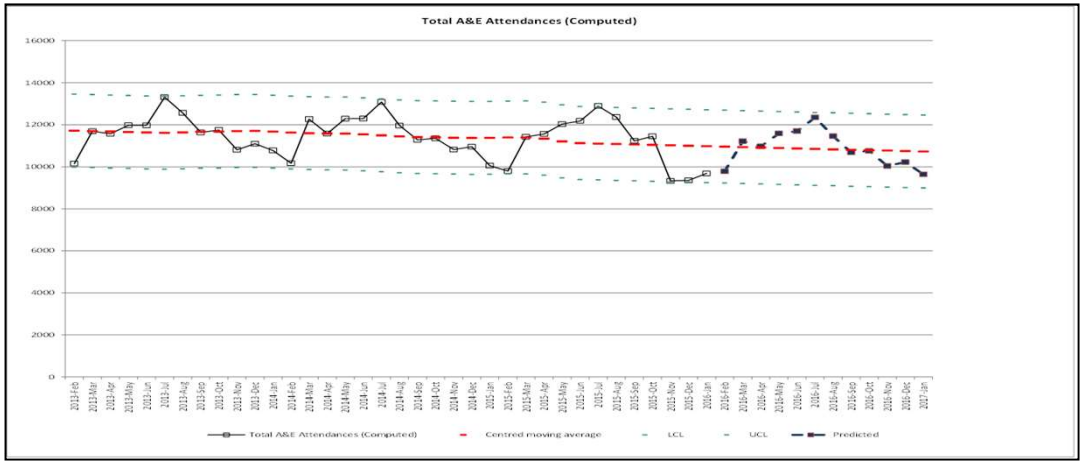
Progress to Date

Reducing the per-capita cost of care:

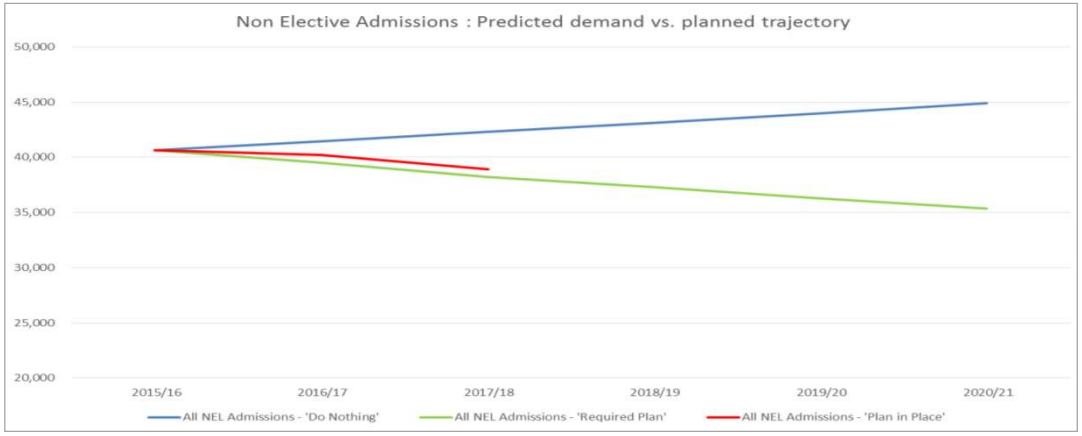
- We are embedding whole systems approaches to **primary prevention, self care and self management,** and are developing core self management tools based on a recent survey of over 700 people with LTC's
- We are implementing a fully integrated stepped **Technology Enabled Care Services (TECS)** model, the level of intervention based on admission risk, and aimed at providing an alternative response to conveyance to hospital and increasing independence of clients in need to remain in their own home
- We have agreed an **integrated workforce plan** for front of each hospital site (Eastbourne District General Hospital and Conquest), with extended multi-disciplinary support 7 days a week. This includes extending voluntary services - Take Home and Settle - and introducing a non-clinical navigator role.
- **Elective care –** we are looking at ways we can streamline this for patients and clinicians, ensuring local people have choice and are able to make informed decisions
- **Prescribing medicines** - bringing together clinicians and pharmacists from across the spectrum to develop ways of working with local patients to ensure they receive effective medicines as and when they need them. The **Medicines Optimisation Service to Care Homes** went live from April 2016
- **Care-home Plus** - introduction of support for the elderly in need of enhanced support but not to a level of nursing care. Providing cost-effective step-up and step-down capacity within the system

We are starting to see the impact of our initiatives across a range of indicators:

Emergency activity profile: Data presented by Academic Health Science Network shows a downward trend in A&E attendances in East Sussex, during the same period A&E attendances across England have increased by 3%



Predicted impact: emergency admissions



For further explanation of the above, and for more evidence of the impact of our initiatives: http://news.eastsussex.gov.uk/east-sussex-better-together/stakeholders/esbt-outcomes/

Clinical Care Models Overview: Next Steps

Clear articulation of clinical care models including cost and predicted impact

- ESBT partnership has worked collaboratively to develop an integrated Strategic Investment Plan (SIP). This sets out our vision and approach to support delivery of a balanced budget in the ESBT footprint and the sustainability of services. The SIP is made up of two parts: Part 1 is the narrative which sets out the case for change and our vision and values, and outlines the key transformation strategies aligned to the 6+2 box framework. Part 2 contains the detailed financial schedules which model and track the net financial impacts of all current and planned transformation projects, designed to improve population health and wellbeing, the quality of services and reduce the per-capita cost of care. The clinical care models described below are a synopsis of these strategies and interventions.

Name: **Personal Resilience (Boxes 1&6)**

Patients: Whole population focus with targeted interventions to match investment with outcome and address health inequalities

Description of Pathway: Embed personal resilience and across the pathway. Key interventions include – improving outcomes from settings based approaches such as schools, nurseries, hospitals, and workplaces and embedding behaviour change as a core function of all front line staff ensuring services deliver maximum outcome for investment, improving staff health to increase productivity and patient outcomes.

Scale: Cross system

Key Changes:

- A shift in perception from people as passive users of health and care to involved and active participants
- Integrated Lifestyle Services
- Valuing the strengths and talents that individual contribute to improving health outcomes
- Self-care options are embedded and support to make lifestyle changes is integrated
- Interventions are underpinned by evidence and include measures of ability to benefit

Name: **Community Resilience (Boxes 1&6)**

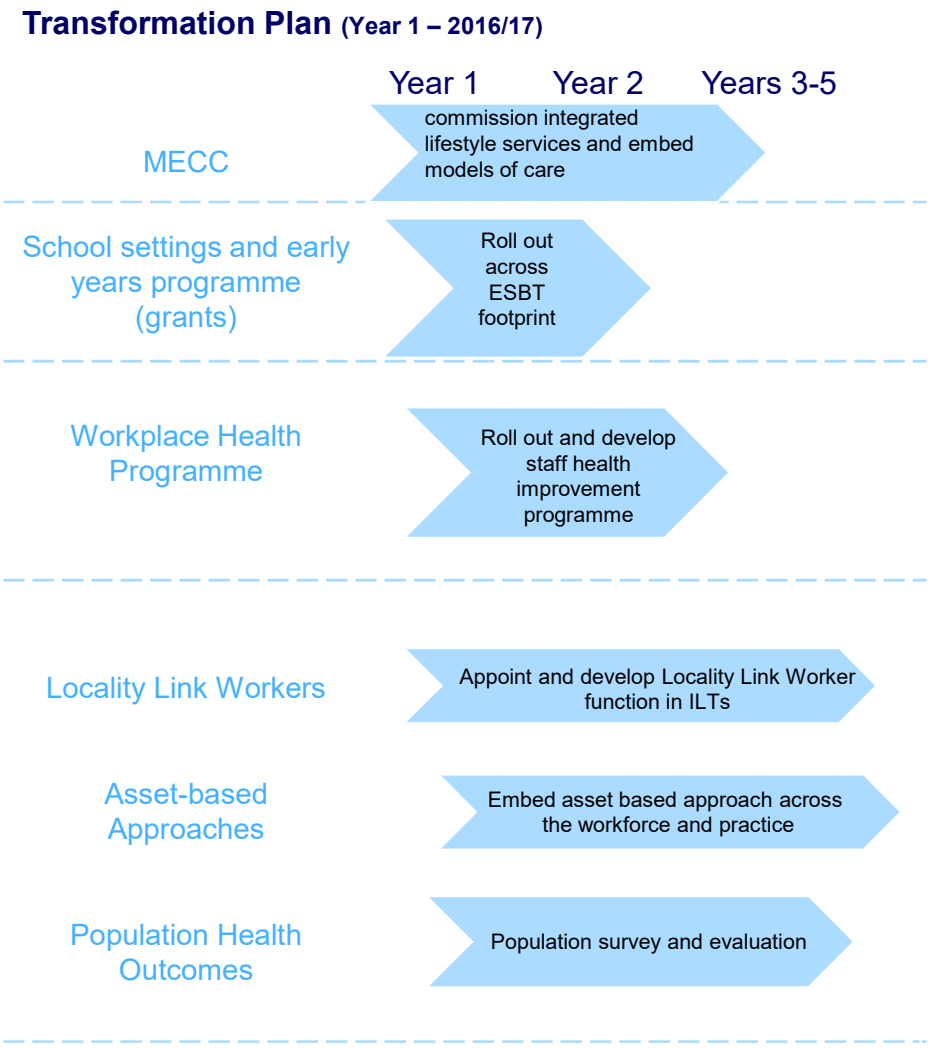
Patients: Whole population focus with targeted interventions to match investment with outcome and address health inequalities

Description of Pathway: Enabling asset-based approaches to be developed and embedded across the system to reduce social isolation, promote healthy ageing, reduce or slow the progression of ill health for people with existing health and care needs and improve wellbeing by growing the protective factors for good health.

Scale: Cross system

Key Changes:

- Reduction in need and demand for formal health and care services
- Reduction in social isolation
- The strengths and talents that communities can contribute to improving health outcomes are valued and harnessed, including embedding these in the support planning process



Clinical Care Models Overview: Next Steps

Clear articulation of clinical care models including cost and predicted impact

Name: **Integrated Locality Teams (Boxes 2&3)**
Patients: Adults
Description of Pathway: Developing integrated community Health and Social Care teams is a key programme of work to bring together core health and social care professionals to provide greater integration and coordination of care to meets the needs of local people within a community setting.

Scale: ESBT footprint
Key changes: Integrated teams with single line management that are aligned to a number of GP Practices, co-located wherever possible alongside agile/remote working, shared IT systems that support risk stratification and case recording, interdisciplinary working, opportunity to develop new and hybrid roles

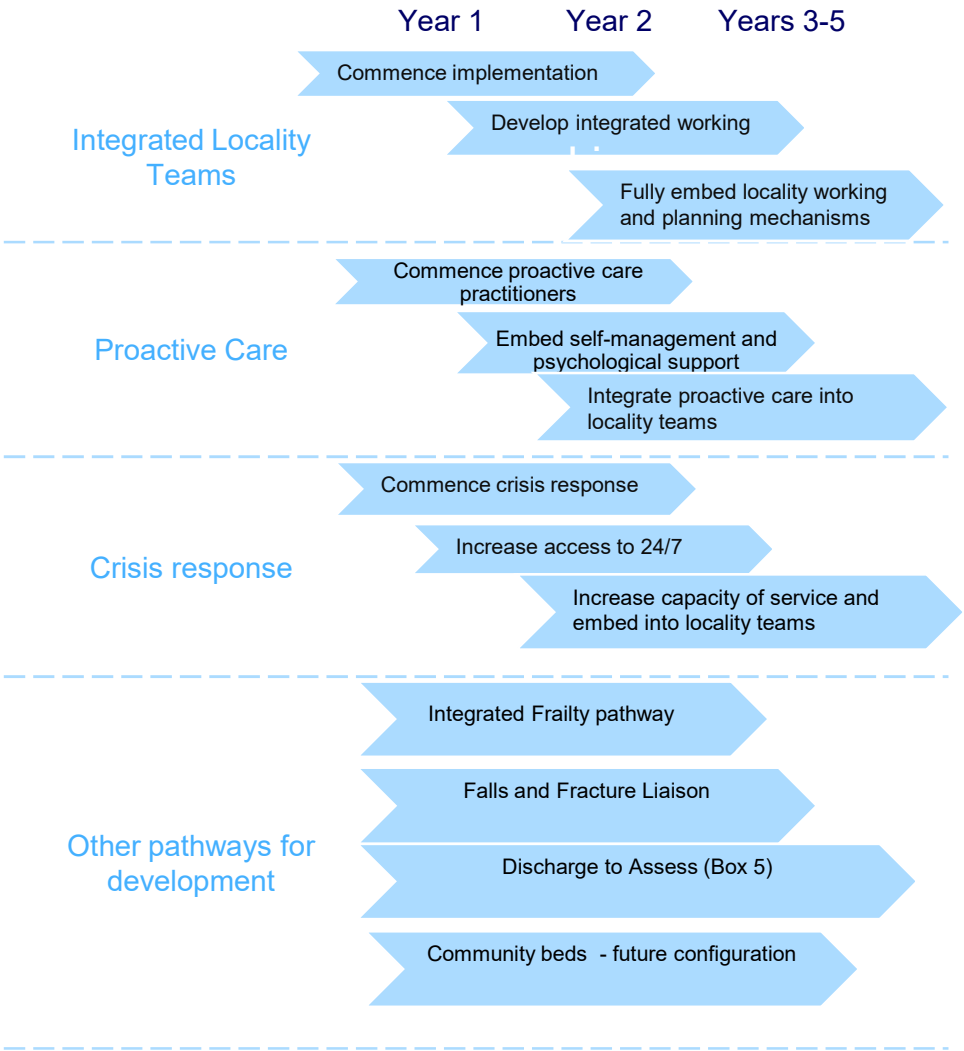
Name: **Proactive Care (Box 2)**
Patients: Adults
Description of Pathway: The proactive care pathway is supported by the use of risk stratification, personalised care planning and access to self management and psychological support.

Scale: ESBT footprint
Key Changes: Enhance capacity and capability for proactive case finding, assessment and care planning; ability to identify patients, clients and carers before they deteriorate and management of more complex cases, ensuring the most effective use of resources and a more holistic approach to care and support.

Name: **Crisis Response (Box 3)**
Patients: Adults
Description of Pathway: Ensuring that integrated health and social care services are set up to be able to respond early and in a co-ordinated way to a crisis, reducing the likelihood of it leading to a hospital admission.

Scale: ESBT footprint
Key Changes: Multidisciplinary response and treatment service in the community with assessment visit within 2 hours. Provide treatments at home, which are not currently available, e.g. IV therapies, and enable patient, client and carers to be supported by intensive support and monitoring packages as appropriate.

Transformation Plan (Year 1 - 2016/17)

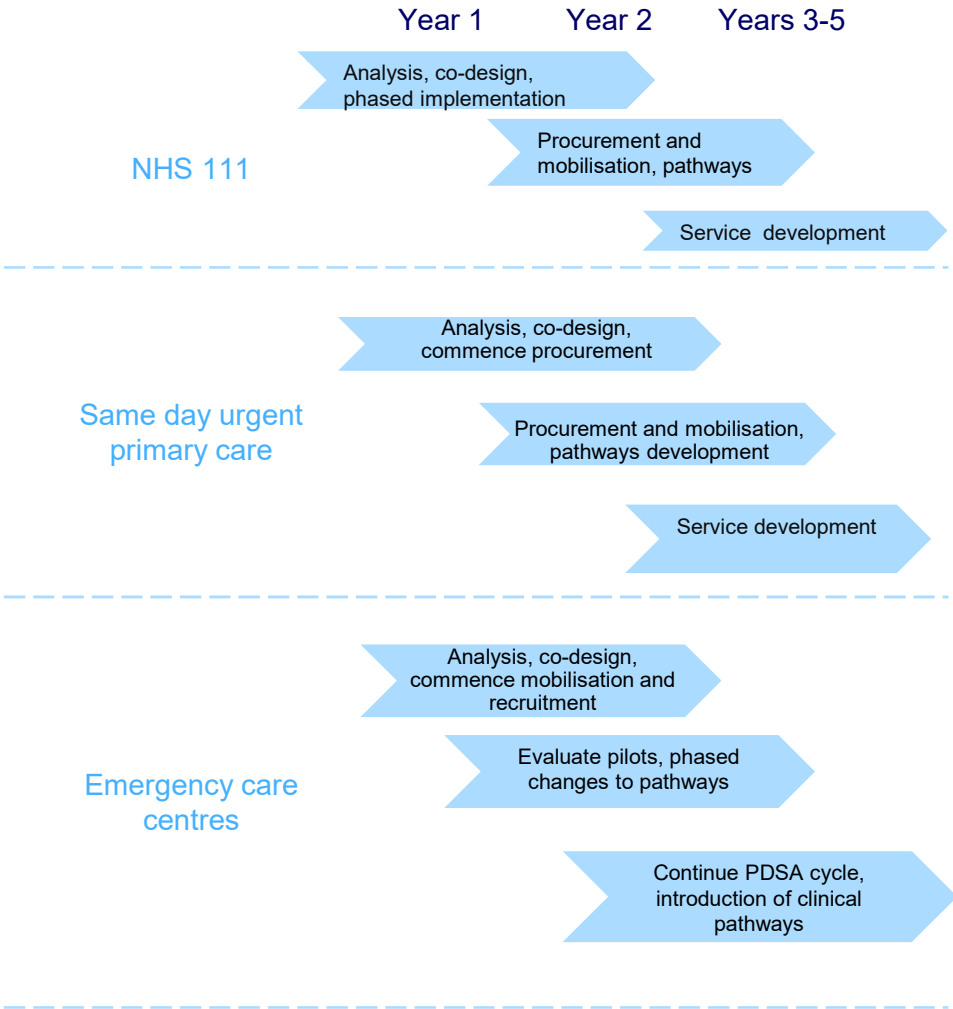


Clinical Care Models Overview: Next Steps

Clear articulation of clinical care models including cost and predicted impact

Name: **Integrated urgent and emergency care: NHS 111 (Box 3)** Patients: All in ESBT footprint Description of Pathway: procurement of an integrated service model of NHS 111 and local clinical triage and assessment service	Scale: ESBT footprint Key changes: design of NHS 111 telephone answering, signposting, self management pathways making best use of technology and life threatening triage process and pathway with 999. Developing a local clinical triage and assessment service to better manage urgent care needs
Name: **Integrated urgent and emergency care: same day urgent primary care (Box 3)** Patients: All requiring service Description of Pathway: 24/7Primary Urgent Care Service accessed via NHS 111 or via own GP	Scale: ESBT footprint Key Changes: Redesign and procurement of a 24/7 urgent primary care service to include current GP OOH service, 2 walk-in centres and overflow support to in hours practices to bring together into one service model that provides consistent clinical triage and face to face assessment capacity
Name: **Integrated urgent and emergency care centres (Box 3)** Patients: Patients accessing emergency care via current A&Es at both ESHT sites Description of Pathway: enabling streaming and increased primary and social care assessment capability at front of hospital	Scale: ESBT footprint Key Changes: expanding multidisciplinary workforce to better meet presenting conditions. Introducing non clinical navigators and testing extended scope physio roles. Urgent care pathways at front of hospital

Transformation Plan (Year 1 – 2016/17)



Clinical Care Models Overview: Next Steps

Clear articulation of clinical care models including cost and predicted impact

Name: **Accommodation & Bedded Care: Integrated Equipment & Adaptation (Box 4)**
Patients: Adults
Description of Pathway: Default / core offer at key points of entry and transition through pathways. Housing solutions input locality teams with 'Housing First' approach

Scale: ESBT footprint

Key Changes: integration of funding, assessment and deployment leading to efficiencies in operational costs and reduction in appropriate admissions; reduced costs due to housing solutions intervention and innovative and flexible use of funding; effective demand management

Name: **Accommodation & Bedded Care: Step-up/Step-down (Box 4)**
Patients: Adults
Description of Pathway: Development of a range of options to avoid admission and facilitate timely discharge; secure options in alternative settings to reduce demand on IC and reduce flow to acute; support to residential care market to flex service model

Scale: ESBT footprint

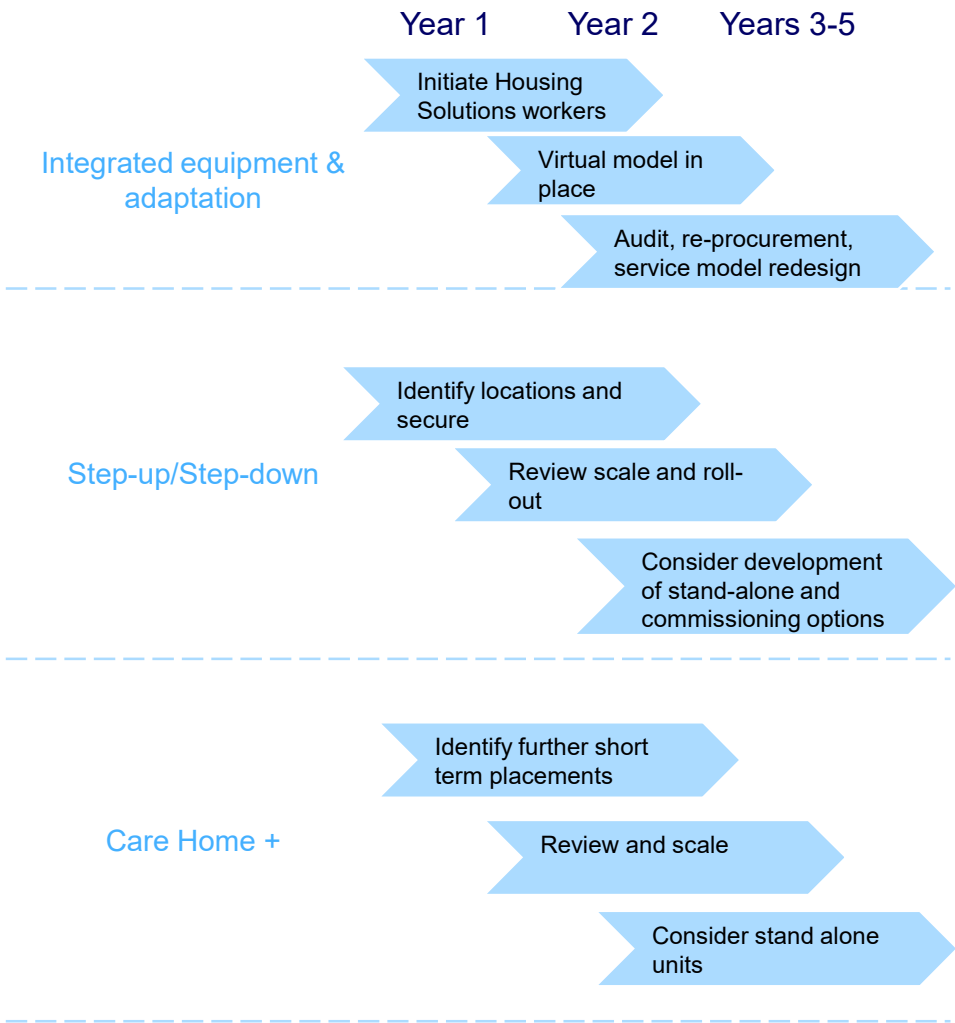
Key Changes: creation of alternative default options to A&E; based settings utilised to meet identified need; integrated pathway; preventing loss of independence and long term placements; securing ongoing capacity in market

Name: **Accommodation & Bedded Care: residential and nursing care (Box 4)**
Patients: Adults
Description of Pathway: Care Home+, enhanced residential care based service that prevents clients being transferred to nursing care when not required

Scale: pilot

Key Changes: releases capacity for genuine nursing needs, and provides market leverage to incentivise change

Transformation Plan (Year 1 – 2016/17)



Clinical Care Models Overview: Next Steps

Clear articulation of clinical care models including cost and predicted impact

Name: **Prescribing (Box 6+1)**

Patients: Adults

Description of Pathway: Prescribing Support Scheme to incentivise prescribers to change behaviour; providing additional expertise to support Prescribers in Primary Care; DAAT service; implementation of joint formulary; integration of Community Pharmacy Medicines Use reviews in GP process and implementation of shared decision making tools

Scale: ESBT footprint

Key Changes:

- Reduction in inappropriate variability in prescribing of medicines
- Evidence-based cost-effective use of medicines across pathways
- Improved safety and efficiency of repeat prescribing process
- Value for money

Name: **Elective Care (Box 6+2)**

Patients: adults with long term conditions

Description of Pathway:

- Shared decision making
- Cardiology
- Diabetes

Scale: ESBT footprint

Key Changes: Pathway Redesign: Aimed at Disease prevention, standardisation and removal of variation. Achieve upper quartile performance Acute Reconfiguration

Name: **Primary Care**

Patients: All

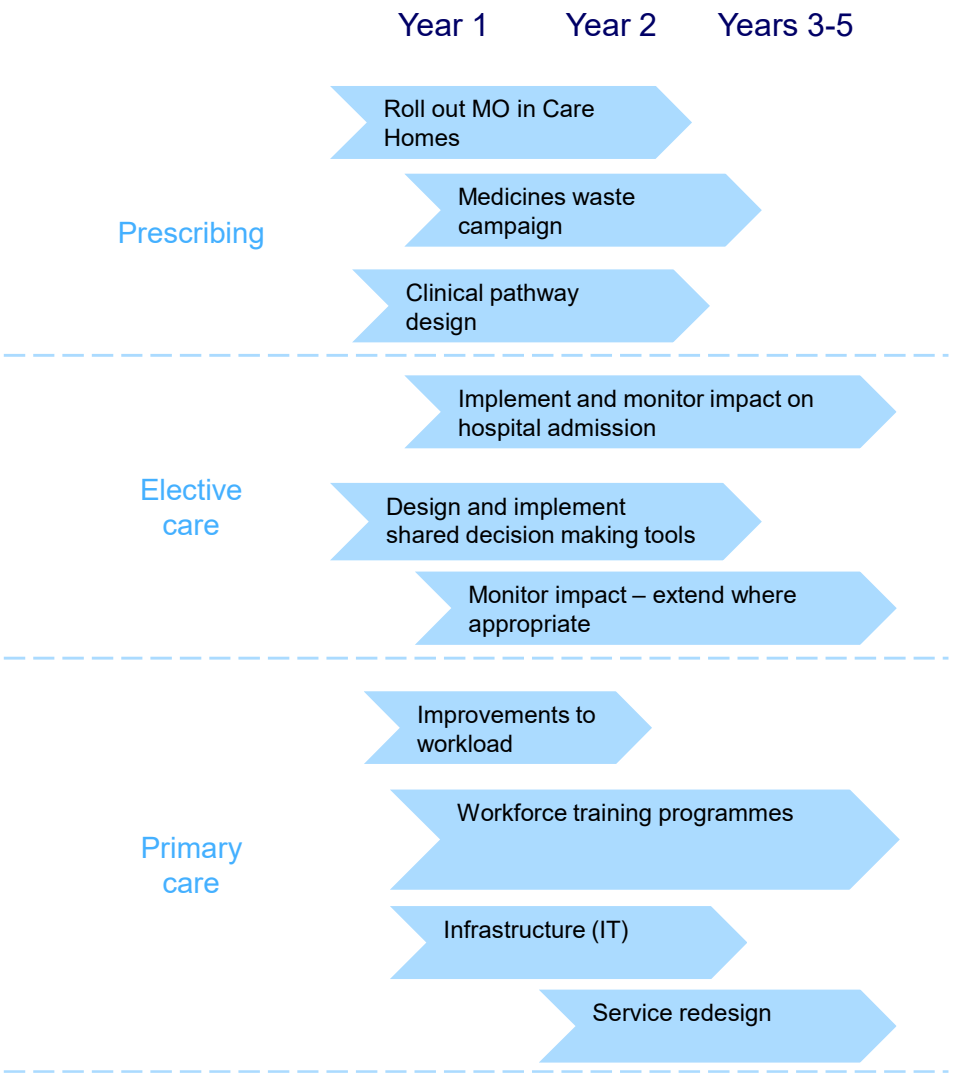
Description of Pathway: supporting changes to primary care working practices; establishing a sustainable workforce; rationalising and improving the estate in primary care; delivery of a GPFV Implementation Plan

Scale: ESBT footprint

Key Changes:

- Incentivising recruitment and retention
- Develop roles to enhance GP support
- Triage to support primary care workload
- Use new technologies and better use of estate

Transformation Plan (Year 1 – 2016/17)



Clinical Care Models Overview: Next Steps

Clear articulation of clinical care models including cost and predicted impact

Name: **Mental Health**
Patients: Mental Ill Health & Dementia
Description of Pathway: Streamlining and simplifying routes into mental health care and support; de-stigmatisation of service provision; increase in third sector/peer support provision; extension in effective interventions to promote self-care and wellbeing; increase in community provision; prevention of deterioration and hospital admission

Scale: ESBT footprint
Key Changes:
- Development of crisis response
- Streamlined rehabilitation pathways
- Expanding role of third sector and Primary Care
- Dementia Crisis Team
- Dementia Shared Care Wards
- Expansion of access to psychological therapies particularly for LTCs
- Reduction in out of area beds

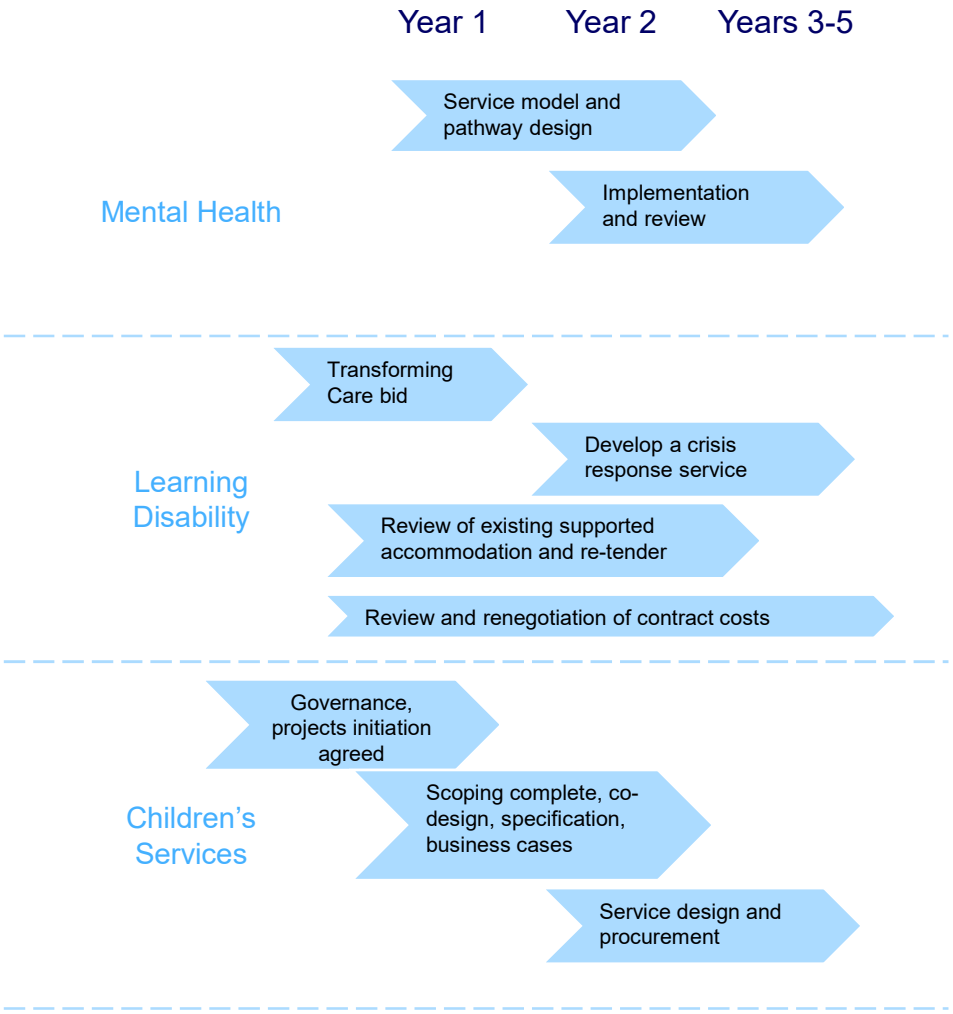
Name: **Learning Disability**
Patients: Learning Disability
Description of Pathway: strengthening the support pathway and provision to adults with a LD and challenging behaviour; improving hospital and primary care liaison; developing a crisis response service to maintain individuals in the community.

Scale: ESBT footprint
Key Changes:
- Increase in people supported to live ion local community settings
- Reduction in numbers of people in in-patient settings
- Consolidation of approach to market and fee levels

Name: **Children's Services**
Patients: Children
Description of Pathway: integrated delivery of Early Help services; improving offer for children with disabilities and special educational needs; improving mental health and wellbeing through the CAMHS transformation plan

Scale: ESBT footprint
Key Changes:
- Reduction in number of children requiring services
- Reduction in number of Looked After Children
- Increase in children able to remain in their local communities with their families
- Improved health and wellbeing

Transformation Plan (Year 1 – 2016/17)



Finance

Summary of current, do nothing and future state investment by programme

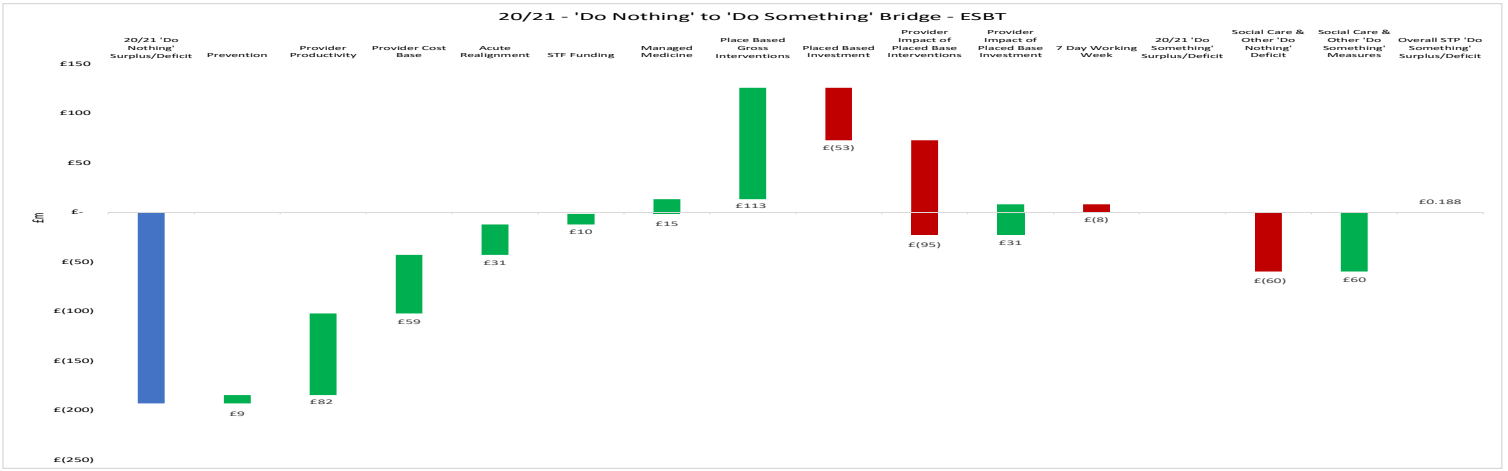
Expenditure (CCG Model)	2015/16	Inflation	Provider Efficency	Growth	Cost Pressures	"do nothing" Scenario	interventions	Provider Efficiency	investment	STF Funding	Cost Base Reduction	2020/21 position	Growth	Change from 2015/16
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	%	%
Acute - Local	285,809	40,310	-25,709	26,615	-5,047	321,978	-108,288		0			213,690	9%	-25%
Acute - Specialist	86,199	0	0	25,182	0	111,381	0		0			111,381	29%	29%
Adult Social Care	123,506	0	0	44,760	0	168,266	-49,132		0			119,134	36%	-4%
Children's Services	29,354	0	0	6,520	0	35,874	-11,033		0			24,841	22%	-15%
Community	42,004	5,764	-3,982	4,041	-3,849	43,979	0		35,707			79,686	10%	90%
Corporate	12,946	542	0	0	-42	13,447	-412		0			13,034	0%	1%
Mental Health	47,623	7,019	-4,845	4,677	-2,845	51,628	0		2,000			53,628	10%	13%
Other inc CHC / BCF / reserves	54,748	3,479	0	5,323	50,887	114,438	-2,751		-4,768			106,919	10%	95%
Prescribing	70,973	19,201	0	12,097	-563	101,707	-15,500		0			86,207	17%	21%
Primary Care	60,882	407	0	9,907	1,018	72,215	0		20,000			92,215	16%	51%
Public Health	17,844	0	0	1,957	0	19,801	-488		0			19,313	11%	8%
Total	831,888	76,723	-34,537	141,079	39,560	1,054,713	-187,604		52,939			920,048	17%	11%
Commissioner Gap						-134,665	187,604		-52,939			0		
Providers														
ESHT						-106,500	-95,375	70,669	61,500	10,400	59,306	0		
SPFT						-6,948		6,667				-281		
SECAMB						-5,191		5,660				469		
Provider Gap						-118,639	-95,375	82,996	61,500			188		
Place Based Gap						-253,304	92,229	82,996	8,561			188		

Future state modelling is currently being undertaken to understand the required activity levels in all sectors to deliver the growth assumptions above. NWAHSN is currently undertaking flow mapping in ESHT.

Finance

An overview of financial planning and description of future financing options

Projected Benefits:



Contracting models and implementation:

- Pooled budget and commissioner-provider alliance contract model for test-bed phase of Accountable Care in shadow form starting in April 2017; introduction of some outcomes based incentives (limited risk during test-bed year); schedule of capitation payment model development and service scope in place with governance to oversee progress and impacts; shadow running schedule and operating model in place and milestones to develop evidence base and options, prior to implementation of capitation and gain/loss share post March 2018.
- We are currently finalising our future state modelling of the high level system architecture required to deliver health and social care on an integrated, system-wide basis. This will include identification of the additional investment and activity required in primary and community services to shape how the prevention and proactive care agenda are reflected in the provider landscape, and will outline what our hospitals will look like together with their connection to more specialist acute clinical networks where services are best provided across a larger population area as our local place-based approach supports the evolving Sussex and East Surrey STP.

Enablers

Key Enablers	Description	Priority Action
East Sussex Health and Care Accountable Care model (PACS style new model of care)	Move to a PACS-type commissioner provider alliance model to incentivise community–based prevention and population health; change financial and contracting models to incentivise coordination of service provision across care pathways to deliver prevention and proactive care. Our model encompasses all local services for adults and children, including primary, community, acute DGH, mental health and social care.	Implement planned development to collaborate as commissioners and providers across acute, community, primary, mental health and social care in a PACS-type model to run a test-bed phase from April 2017 – March 2018, supported by a pooled budget and integrated strategic investment plan. Introduce some outcomes based incentives (limited risk during test-bed year); establish schedule for a capitated payment model and service scope, with governance arrangements to oversee progress and impacts; and put in place a shadow operating model and milestones to develop evidence base and options for post March 2018. The model envisages there being no barriers between primary and acute care and sees primary care being delivered at scale. A mixed model is envisaged to allow primary care providers to engage according to their preferences and circumstances, for example as Federations or individual practices. The LMC have been involved in our Accountable Care workshops and we continue to regularly engage them in the development of the model.
Integrated Strategic Planning & Investment Framework	The integrated Strategic Investment Plan outlines the combined health and social care spending profile up to 2021. The aim is to change the system by increasing investments in primary and community based services and through rationalising shared budgets. The next step is to develop the joint commissioning of services across the breadth health and social care within a single process. The development of an Integrated Strategic Planning and Investment Framework will align the strategic, planning and delivery functions where appropriate and where this helps us to fully deliver the move to a system of accountable care.	The scope of this work includes: •Bring together the strategic planning and delivery functions within the County Council across ASC, Children Services, Joint Commissioning and Public Health •Align this to the strategic planning and delivery functions within the local two Clinical Commissioning Groups (CCGs) •Model what functions would work best if they worked together more closely across the CCGs and social care, or operated as a single function •Re-organise joint commissioning functions to support commissioning as a single voice within a model of accountable care for shadow running in 2017/18

Enablers

Key Enablers	Description	Priority Action
Workforce	Creating an integrated workforce that is equipped to deliver the new models of care and working to address current workforce issues	The ESBT Workforce Strategy sets out our plans to create a workforce equipped to deliver the new models of care required as part of system transformation. Our workforce is key in delivering integrated place based health and care services, supporting a proactive and preventive approach as well as ensuring the right workforce is able to deliver the right care in the right setting. Our strategy provides a framework for a targeted approach to workforce planning, that is able to respond the evolving needs of the ESBT programme, and is underpinned by a clear governance structure, that fully supports our system-wide partnership approach across commissioners and providers. ESBT has invested in a Head of Workforce Planning to lead and facilitate workforce transformation at pace. There is a Strategic Workforce Group that reports to the programme board, supported by a Workforce Planning Resource Group to which all system workforce leads contribute. There are immediate challenges regarding the workforce supply issues of several key professional groups across both health and social sectors. As such, a Workforce Task and Finish group with provider workforce representation has been formed to explore and implement joint workforce supply solutions that avoids 'robbing Peter to pay Paul' scenarios and simply shifting pressure to other parts of the system. A programme of work has been agreed for the first year of the Workforce Strategy; key to this is the development of new roles to meet the needs of our population, alongside implementing a range of recruitment and retention initiatives. We have established a Community Education Provider Network on the ESBT footprint. Our education, training and development is to be approached on a system wide basis through the ESBT Strategic Workforce Group, and increasingly through the as it matures and commissions a range of education and learning initiatives for primary care and other system providers.

Enablers

Key Enablers	Description	Priority Action
Communication & Engagement	The ESBT Communication and Engagement Strategy **aims to** inform, involve and empower a range of local stakeholders the redesign programme. Engagement has included care pathway design and implementation of new models of accountable care. Engagement is fully integrated into our programme governance arrangements and action includes the establishment of a Public Reference Group and advisory group approach	Our strategy will continue to be implemented and this has four key aims: create a culture of co-design – making co-design the way we engage and communicate; facilitate a conversation about system-wide transformation and the development of new models of care; improve access to and quality of information; further develop relationships that are wide, collaborative and inclusive. Key priorities include: East Sussex Health and Care (PACs style Accountable Care) phase 2 development September 2016 – March 2017. • Phase 1: Case for change discussion phase (January – July 2016: completed) • Phase 2: Engagement phase to inform the design of the model (September 2016 - March 2017) • Phase 3: Engagement phase to inform implementation and local accountability during the test-bed year of Accountable Care in shadow form (April 2017 – March 2018)

Fore more information please see: http://news.eastsussex.gov.uk/east-sussex-better-together/get-involved/

Enablers

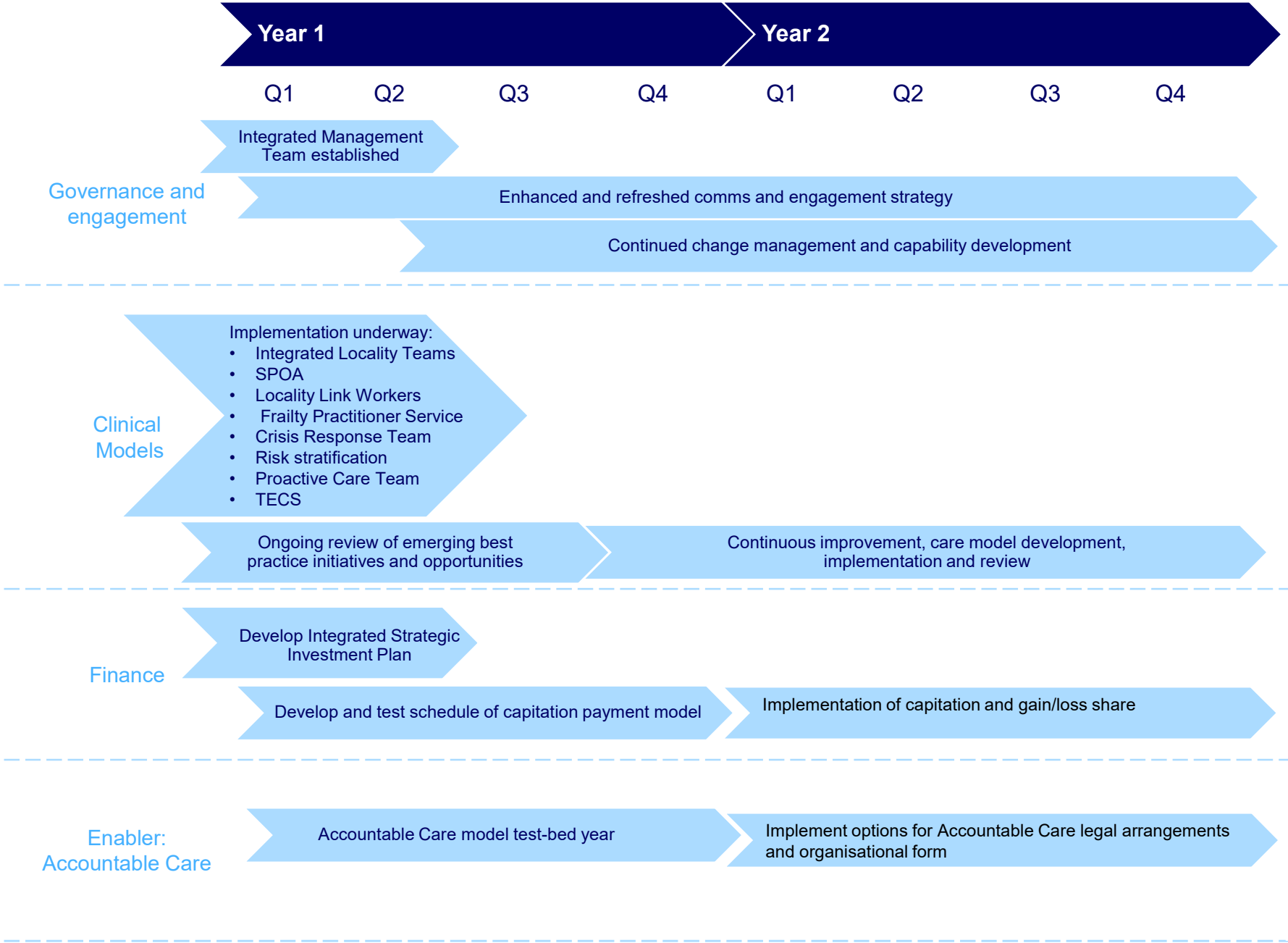
Key Enablers	Description	Priority Action
Estates	To support the development of integrated cross-organisational working requires a radically different and updated estates strategy	A strategic estates plan that will: • Look to review and rationalise the existing health and social care estate across the ESBT footprint (e.g. co-locate teams where possible) • Ensure access to safe and high quality buildings for our population, as part of a high quality user experience of health and social care • Ensure the estates strategy is aligned to the strategic shift away from hospital / residential settings into the community • Adapt our estates to support modern working arrangements • Establish whole systems working and governance for estates management across the ESBT footprint
External support and income generation	Development of a strategic external funding plan to attract additional investment or pump-priming money into East Sussex to support our strategic objectives and delivery of our plans at pace.	We will be focusing on two priority areas: • Funding available to the ESBT programme to principally support the development and/or delivery of formal health and social care interventions, e.g. research grants, innovation awards, etc. • Funding available to support wider health, wellbeing and preventative objectives identified at a strategic and locality level, and in accordance with the outcomes of community engagement e.g. Big Lottery Reaching Communities, grant making Trusts etc.

Enablers

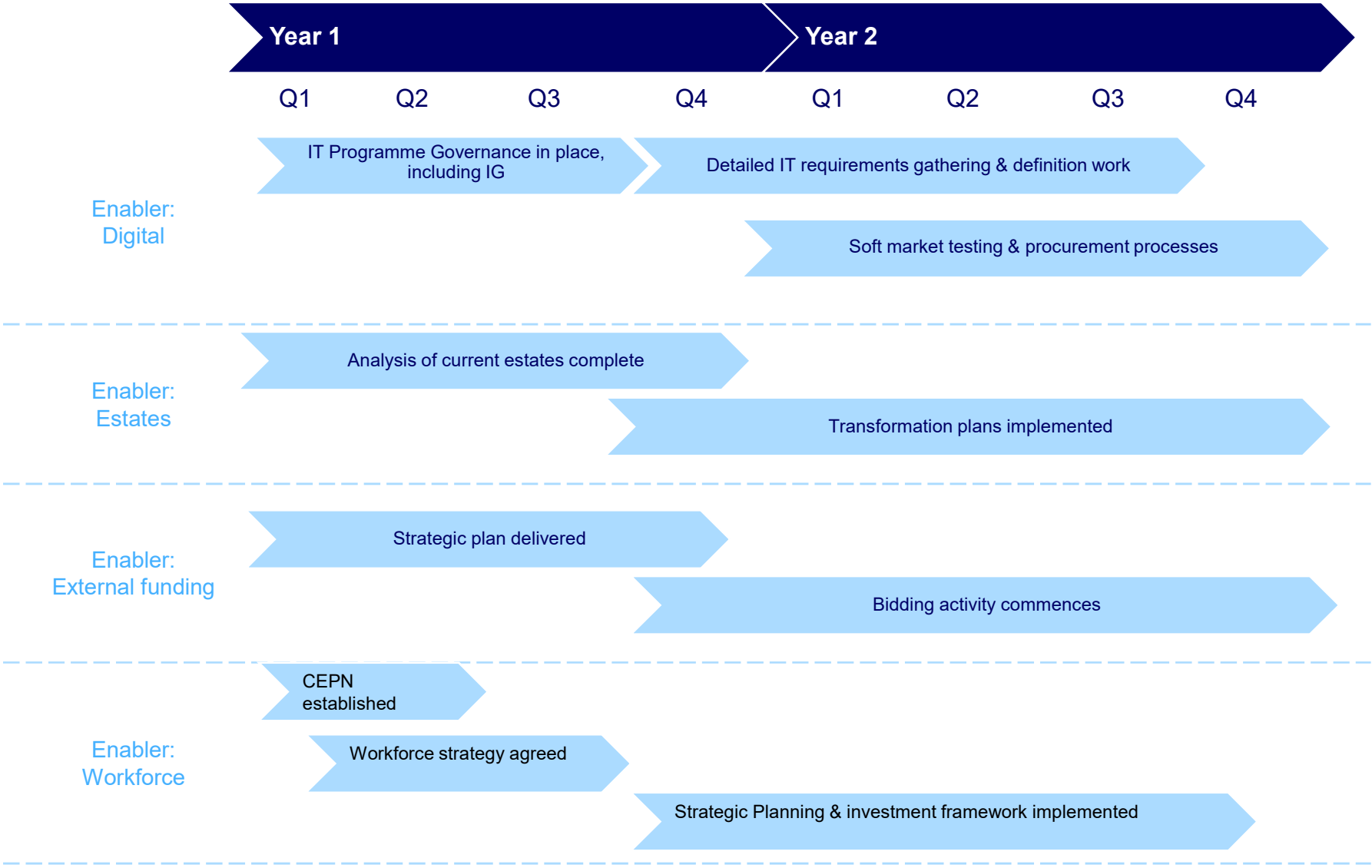
Key Enablers	Description	Priority Action
Digital	The adoption of enabling technologies that provide a set of core competencies for an integrated health and social care economy in regard to the sharing, management and processing of patient data.	The Local Digital Roadmap lays out a comprehensive set of system deployments and enhancements aimed at bringing a truly joined up infrastructure to the health and social care economy for ESBT as well as the wider STP footprint. Contained within this are a core set of ten universal capabilities and another ten capabilities that all stakeholders have agreed constitute the critical elements of the 'future state' system architecture. These include: •Integrated Digital Care Record •Analytics (including Proactive & Predictive) •Digital Correspondence •E-Prescribing •Mobile Working / Workforce Agility •Citizen Portal / CRM •Telehealth / Telecare / Self care Work to define detailed requirements is being completed 2016, leading to procurement (starting with IDCR) and funding bids for 2017.

Further information regarding our approach to the key enablers underpinning our transformation programme and plans can be found in the Strategic Investment Plan narrative attached at Appendix 1

Timeline for continued ESBT and accountable care model delivery



Timeline for continued ESBT and accountable care model delivery



•**Version Control:**

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