Sussex and East Surrey Sustainability & Transformation Plan

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Name of footprint and no: Sussex and East Surrey (33)

Region: NHSE South

Nominated lead of the footprint including organisation/function: Michael Wilson, Chief Executive, Surrey and Sussex Healthcare NHS Trust

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22nd November 2016

Our "plan on a page"

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Sussex & East Surrey Sustainability & Transformation Plan

Context and challenges: We are a large and diverse region, with 23 organisations serving 1.7m people. We have significant challenges with waiting times and cancer outcomes, alongside a relatively older population. We have established three "Place-Based" areas (Delivery plans in Appendix B), each defined around local communities, empowered to co-design person-centred services, led by GPs with support from a wide range of professionals. Our challenge is to improve the health of our communities, make it quicker and easier to access services, to deliver improvements identified by regulators and find a way to do so within a tighter budget than we have faced in many years.

Benefits:

Years 1-2	Years 3-4	Year 5
Quality: Waiting time targets met or exceeded, All trusts exit special measures, all GPs working in a new way, e.g. in a locality and delivering person-centred frailty models. GP appointments available more readily for all communities.	**Quality:** Each Place to have at least one walk-in primary urgent care with max 30 min wait. Hospital performance in top quartile for all measures. All services to have full mind and body integration/approach	**Quality**: patients report having full ownership of care and wellbeing for all LTCs and frailty
Performance: Delivery of agreed trajectories in year 1. Further improvement in performance in year 2.	**Performance**: Minimum constitutional targets met and improved outcomes where performance is poor e.g. lung cancer, EIP and IAPT Access delivered,	**Performance:** Prevention goals achieved, ~20% reduction in bed days per 1,000 population
Finance: Overall position improved by £147m	**Finance**: Further efficiencies of £279m delivered	**Finance:** overall position £60m deficit

Priorities:

Years 1-2: Addressing the quality and performance gap

Place based transformation:
Accountable Care: ESBT/Coastal new models in place by Year 2 with pooled budgets Y1 in ESBT. CSESA significant progress towards MCP and collaborative commissioning
Primary care: Make GP services easier to access and work better for patients, and integrate multidisciplinary teams.
Frailty (primary care): led by primary care, develop services for older people that respond to their complex needs;
New primary and community urgent care models: networked with acute hospitals, aiming to make better use of resources

Whole system: acute recovery plan (Appendix C):
Capacity review: making the best use of existing beds
Community beds: new community beds (primary care and community led in partnership with BSUH and ESHT)
Elective redesign: share resources to improve efficiency
Discharge delays: reduce blockages in the care system to free up capacity to care for those who need it most
Networked hospital care: working together on cancer, stroke, pathology and imaging, and to deliver seven day services

Years 3-4: Accelerating transformation

Place based transformation:
Accountable Care: place-based decision making and financial incentives implemented, e.g. capitated budgets
Innovation across all LTC pathways, primary care and mental health: each place empowered to drive local transformation building on best practice sharing
Workforce transformation: training for new roles and workforce productivity plans implemented and contracts to underpin community based models and deliver a motivated and engaged workforce
Mind and body care: all models to have full "holistic" approach

Provider sustainability:
Elective centre: Build on initial partnerships to deliver transformed model across whole STP footprint
Networks for DGH services: mapped patient pathways to underpin new model of acute collaboration through acute networks
Specialised integration: ensure delivery of transformational schemes to underpin future configuration around Brighton

Year 5: Embed transformation

Transformed Place based care:
Continue to transform and integrate care, led by GPs and integrated mind and body teams, with further local innovation and tailoring to deliver the needs of local populations to remain independent and healthy

Completion of:
Deliver future Brighton hospital: MTC and teaching hospital
Deliver on patient pathway integration and implications for acute sites

Supported by: Estates | Digital | Workforce | Comms & Engagement

Executive summary

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This document summarises our work in progress plans to improve the quality of care patients receive, make it easier to see a GP or to use specialist services and to deliver services within the money available. It builds upon our submission of 30th June 2016, and should be seen as work in progress to guide delivery of change. We will need to co-create the detail of solutions with local communities and we will significantly expand our engagement activities to achieve this.

We are committed to working as an STP footprint as we believe this is the only way to achieve change at scale and specifically to achieve acute networking and pathways, support our tertiary services and facilitate transformation in partnership with organisations that span the whole footprint (mental health and community).

Our STP footprint shares the challenges and opportunities of the rest of the country in delivering the triple aim of STPs, with particular challenges locally due to our population demographics, performance of some providers and CCGs and our overall outcomes particularly in Cancer.

Our aspirations for longer term transformation and delivery of the 5YFV, including GP and Mental Health 5YFV will be driven by our three “places” – with each aiming for an accountable care model, and an agreed focus on three areas for next year as an STP (in addition to local priorities): frailty, urgent care and primary care transformation. We have significantly progressed our governance as an STP to enable this local work to flourish, and there has been significant movement in the development of localities or care practice groups of GPs in each of our areas. (Appendix B for delivery plans)

The added value of working as an STP across the three places is the ability to share learning and speed up transformation and to make clear links between the granular person centred care plans and our commitment to furthering acute networking for secondary services as a whole STP.

We acknowledge that despite this good progress we have some particularly acute challenges that require focus in the short term to deliver system sustainability this winter:

- Operational performance challenges in A&E and RTT, and for Cancer
- Significant financial challenges at a number of trusts and commissioners; most notably BSUH, but also ESHT, SECAmb and two CCGs

We believe that the largest opportunity to solve these issues and prepare for winter is to maximise the number of acute beds, particularly across BSUH sites, where approx. 86 have been lost in the past year, and at ESHT where there is a projected shortfall of 66 beds between the two sites. (Appendix C for recovery plans)

Our STP has brought organisations together to develop a shared plan to solve the bed shortage. These resilience plans are founded upon a mix of: opening additional capacity at RSC site through internal reconfiguration and optimisation of space, opening additional community beds at existing sites, and working in partnership with social care to deliver nursing solutions to decompress acute sites. These are in addition to whole system daily capacity management “operations rooms” that have been established by ESBT and are being designed rapidly for Brighton and catchment.

We have a history of working in acute networks e.g. vascular/stroke services and our aspiration is to build on this to design a networked future for secondary care. The detailed work for this winter has also rapidly progressed a number of medium term actions for years 2 and 3, that will link with this networking including elective care factory, balancing capacity for both daycase and elective work across sites and driving economies of scale.

We remain committed to delivering the efficiency improvements set out by the centre. However we have found that the scale of our starting performance and finance challenge raises concerns around material safety issues in relation to winter capacity. Therefore we will not be able to submit a plan that balances and meets CCG business rules in all years. We have not made this trade off lightly and are keen to discuss and test our assumptions with you, as well as to continue to work to find solutions to further close the gap.

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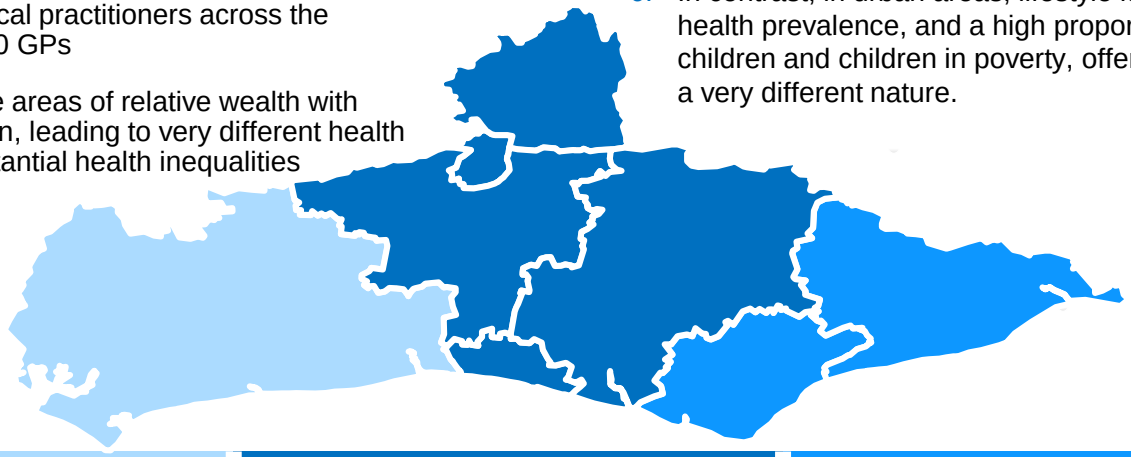
Our sustainability and transformation footprint

1. Our footprint is home to 1.7 million people providing health and social care at a cost of £4bn
2. 23 partner organisations are involved across all health and social care sectors
3. There are over 37,000 medical practitioners across the footprint including over 1,000 GPs
4. The footprint combines large areas of relative wealth with pockets of severe deprivation, leading to very different health challenges, along with substantial health inequalities
5. We have a larger than average elderly and ageing population, which when combined with the rural areas and variable transport links makes supporting this complex and vulnerable cohort a significant challenge.
6. In contrast, in urban areas, lifestyle factors and mental health prevalence, and a high proportion of looked after children and children in poverty, offer equal challenges of a very different nature.



Coastal Care

Coastal West Sussex CCG
Sussex Community NHS Foundation Trust **(SCFT)**
Sussex Partnership NHS Foundation Trust **(SPFT)**
West Sussex County Council
Western Sussex Hospitals NHS Foundation Trust **(WSHFT)**
South East Coast Ambulance Service **(SECAmb)**
GP Providers
IC24

Central Sussex & East Surrey Alliance (CSESA)

East Surrey CCG
Crawley CCG
Horsham & Mid Sussex CCG
Brighton & Hove CCG
High Weald Lewes Havens CCG
Queen Victoria Hospital NHS Foundation Trust **(QVH)**
Surrey & Sussex Healthcare NHS Trust **(SaSH)**
Surrey & Borders Partnership NHS Foundation Trust **(SaBP)**
Brighton & Sussex University Hospitals NHS Trust **(BSUH)**
Sussex Community NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Brighton & Hove City Council
West Sussex County Council
East Sussex County Council
Surrey County Council
First Community Health & Care
SECAmb
GP Providers
IC24

ESBT

Eastbourne, Hailsham and Seaford CCG
Hastings and Rother CCG
East Sussex Healthcare NHS Trust **(ESHT)**
East Sussex County Council
Sussex Partnership NHS Foundation Trust
SECAmb
GP Providers
IC24

Our vision for Sussex and East Surrey

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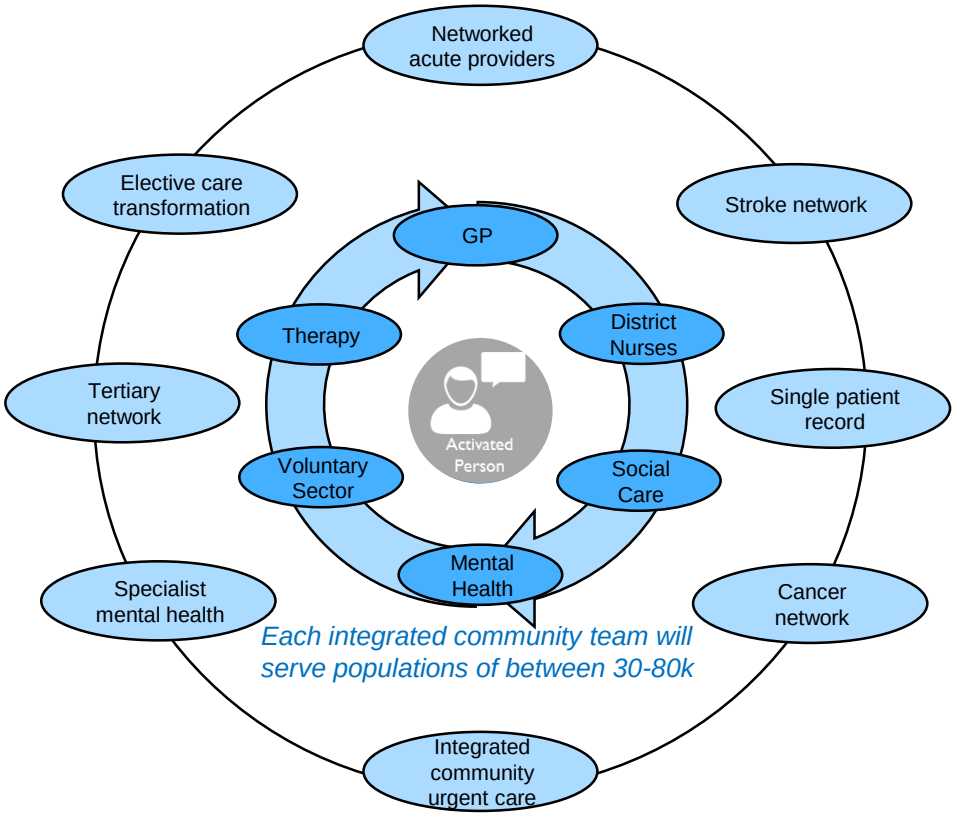
Key principles

1. Full engagement of local populations to support us in delivering the best outcomes with available resources
2. Led by place-based integrated care in our 3 “places” to be responsive to the range of needs of our population
3. Focused on prevention and proactive care through multidisciplinary locality teams supported by a shift in investment towards Primary Care and Community
4. Supported by a provider sector that collaborates to network services, share workforce, and balance capacity across the system
5. Move at pace, and support local organisations to go as fast as they can, recognising different starting points of each of the 3 Places

Our Ambition

- Our ambition is to improve population health and wellbeing by working together as an STP footprint
- Prevention and self-care is central to all of our plans to prevent illness and enable people to live well
- The care you receive will be integrated and all of the people and organisations involved will be centred around you and in communication with each other
- Where care is more specialist – this care will be provided through acute clinical networks to ensure that you receive the highest quality care that meets your needs
- We are committed to having one shared patient record – this means that you will not have to repeat your patient history each time you meet someone new



Each integrated community team will serve populations of between 30-80k

Hospital and specialist mental health services will be arranged over appropriate populations, i.e. 1m to 2m

How has the footprint responded to feedback received on the June 30th submission

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	Feedback received from NHSE/NHSI in July 2016	Actions implemented since June 30th
Leadership and Governance	▪ Governance and behaviours should facilitate stronger collective leadership ▪ Streamline governance and ensure appropriate decision making can occur at pace ▪ Move quickly to address leadership issues where possible ▪ Describe and resource additional programme support arrangements and establish at pace ▪ Work closely with Kent on cross-border issues	▪ Single system leadership (SPoLs) now in place across our three "Places" ▪ Programme Board Executive created to drive STP-wide progress with agreed behaviours and principles as contained in Appendix A of this document ▪ Workstreams reviewed and enhanced to focus on delivery with Chairs in post to drive change ▪ Programme resource planning – programme director interviews held and offer made ▪ Engagement with Kent STP leaders to align plans
Transformation of local care through "Places"	▪ Provide clearer plans on how the STP will move forward to address the quality gap ▪ Clarity on how place-based plans are being developed in light of the STP ▪ Clarify engagement with local authorities in Estates discussions ▪ Ensure delivery of Primary Care five year forward view is embedded in places ▪ Stronger plans for Mental Health, drawing on the Five Year Forward View	▪ Place based delivery plans accelerated (note differing starting points) – clarity on vision, governance, resourcing, clinical models, contracting and finance, and enabling streams. ▪ Local transformation teams now present in all three places ▪ Clear future state identified for each place, with plans to deliver in Years 1&2, two accountable care models and one commissioner collaborative with an MCP ▪ Further testing of basis (including evidence base) for plans ▪ A Mental Health review panel (across the three places) has reviewed each of the place-based plans to ensure that the main priorities of the MH5YFV are in place ▪ Significant engagement of primary care colleagues in development of all place-based plans
Provider collaboration and transformation	▪ Identification of more radical solutions to close the finance gap ▪ Further develop the options for sustainable acute and specialised services ▪ Ensure compelling case for 3Ts model is developed and is consistent with the STP plans	▪ Agreement to build on existing acute networks to identify future models for networked DGH provision, building on pathways of care that integrate with place-based plans ▪ NHSE led work to assess requirements and sustainability of MTC at BSUH to report December 2016 ▪ Strategy for sustainable elective care in development, building on analysis and ensuring delivery of RTT

Overview of the challenge we face

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- Patients are receiving varied care across the footprint, this combined with poor health outcomes for some means that people are suffering unnecessarily. Coupled with poor patient experience and poor health for some, the financial burden across the footprint is growing. Consequently all stakeholders need to work together to successfully improve care for all in Sussex and East Surrey.

Health & Wellbeing Gap

- The STP footprint has a growing and ageing population, with an increasing number of people suffering from long term conditions (LTCs) and in particular a significant older population living with multiple LTCs. Health is poor in some areas of the footprint, notably in in coastal towns, where pockets of deprivation across the STP lead to significantly poorer health outcomes and fewer disability free years of life lived.
- Specifically, we have gaps across the footprint relating to:
  - Smoking: above average smoking rates amongst 15 year-olds, and some localities with high adult smoking rates
  - Cancer: we perform poorly on 1-year cancer survival, driven in particular by lung cancer
  - Obesity: we have above average rates of adult obesity
  - Mental health: above-average rates of hospitalisation for self-harm

Care & Quality Gap

- We have significant problems in primary care – specifically to patients unable to book appointments within a reasonable time period, old buildings that are not fit for purpose and high vacancy openings that GP surgeries are struggling to fill.
- Within our hospitals:
  - ESHT, BSUH and SECAmb are in special measures
  - Referral to Treatment times, cancer waits and A&E 4-hour performance continue to decline, and are getting worse
  - High vacancies are resulting in very high levels of bank and agency use which is adding further pressure on finances
- Care & Quality problems also exist in other sectors, with variable performance in mental health care, issues in recruitment within social care, and capacity issues where care homes have closed.
- Care and quality issues relating to specific physical and mental health conditions include:
  1. Cancer: early diagnosis rates and poor patient experience
  2. Stroke outcomes: particularly rehabilitation and social support
  3. Mental health detection, access and outcomes
  4. Management of long term conditions (e.g., respiratory): prevention and support
  5. Support to the frail and elderly: End-of-life care, organisational and funding structures
  6. Maternity and children's services: perinatal services, complex families and poverty

Finance & Efficiency Gap

- Total allocated funds for CCGs, primary care, social care and specialised commissioning was £4bn in 16/17.
- In 15/16, the financial gap STP-wide was £127m.
- The ‘do nothing’ financial gap by 2020-21 is predicted to be £864m.
- ESHT and BSUH are in financial special measures.
- STP-wide efficiencies and new models of care must make better use of the £4bn to address this growing financial challenge.
- In November 2016, all organisations within this footprint will reforecast their financial position. This will also give a clearer indication of the system as a whole and will enable STP financial planning from a stable foundation

Transforming care through our 3 localities

Our STP is comprised of 3 'places' responsible for locally driven community and integrated care with the aim of improving health outcomes for our communities and reducing avoidable illness and health and care expenditure.

Each place is building a model that best responds to both the local health needs and context of the health and care organisations in the region, however many commonalities exist between them. Each place will oversee radical clinical transformation of LTCs, frailty, mental health, community, social care, general practice and urgent services to transform outcomes and quality.

Coastal Care

Model: Accountable care model with one capitated budget

Ambition: 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.

Strategic objectives:

- Enhance primary and community care and focus on population wellbeing and early intervention to reduce demand for hospital services
- Successful integration of teams and providers

Initial priorities:

- Develop Local Clinical Networks
- Tackle the challenge of the ageing population
- Redesign urgent care services
- Implement new pathways for planned care
- Carry out targeted service improvements for children to enhance physical and mental wellbeing

Predicted benefits:

- Enhanced primary care
- Sustainable community, mental health and social care provision
- Improved access to specialist expertise
- Communities engaged and developed
- Reduce spend on traditional hospital care by £44m by 20/21 (8%)

Central Sussex & East Surrey Alliance (CSESA)

Model: Multispecialty community provider (MCP)

Vision: To develop pro-active, community-centric and more integrated health system, led by primary care that promotes wellbeing, self care and care closer to home.

Strategic objectives:

- Care designed for the needs of local populations
- Successful integration of providers
- Sustainability of primary care, acute care, community and mental health care

Initial priorities:

- Improve prevention and self care
- Better access to urgent care
- Continuity of care for patients with LTCs
- Coordinated care for frail and complex patients
- System-wide higher quality and performance

Predicted benefits:

- Reduction in emergency and planned admissions
- More episodes of care in the community
- Increased quality of care and patient satisfaction
- Stable, sustainable workforce
- Sustainable primary and acute providers along with sustainable community, mental health and social care provision
- Reduce spend on traditional hospital care by £80m by 20/21 (12%)

East Sussex Better Together (ESBT)

Model: Accountable Care model with capitated funding and pooled budgets

Vision: Develop a fully integrated health and social care system, ensuring every patient enjoys proactive, joined-up care and is able to live fully within the community.

Strategic objectives:

- Improve health outcomes of the population
- Enhance the quality and experience of people's care
- Reduce the per-capita cost of care

Initial priorities:

- Pooled budget Year 1, full ACM in Year 2
- Develop new Integrated Locality Teams
- Provide streamlined points of access for health and social care services
- Develop new models for GP-led urgent and emergency care
- Increase efforts to prevent illness and to promote healthy living and wellbeing

Predicted benefits:

- Improved community health and wellbeing
- Better user experience of services
- Cost of care is sustainable and affordable
- Staff able to make the most of their dedication, skills and professionalism
- Reduce spend on traditional hospital care by £44m by 20/21 (14%)

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STP-wide place-based priorities (Years 1-2)

Since June, this STP has sought to collaborate in a way that has not existed before now. Our leaders recognise we can do more for our communities, faster, if we work on the following priorities collaboratively across the three places. Whilst the models will differ according to local context, there are strong commonalities in approach.

	Urgent & Emergency Care	Frailty	Primary Care
SRO	Marianne Griffiths	Keith Hinkley	Geraldine Hoban
Case for change	Currently the STP footprint is experiencing a high number of avoidable A&E attends in part due to inconsistent opening hours across each of the three places. Links to GP services also require strengthening to deliver a 'joined-up' system.	Our STP footprint has an older than average population, and, in common with the rest of the country, services are currently fragmented and do not support people to live independently.	A lack of historic investment and significant shortages of GPs across the footprint has resulted in multiple list closures and the population struggling to access primary care in places.
Vision	For all Urgent & Emergency Care Centres to be networked and linked with an ED, and embedded in a primary care community of practice, to enable a highly responsive service and for patients to be cared for as close to home as possible.	People living with frailty to be treated proactively in a coordinated and well managed way. Patients receive care that better reflects the complexity of their needs, closer to home and in the community as much as possible.	Strengthened GP services, through locality teams (or communities of practice), that coordinate care of patients – improving access, outcomes and delivering greater value to communities from available funding.
Benefits	▪ Improved A&E performance – key underpinning action to achieve target trajectories ▪ Better support for people and their families to self-care or care for their dependents ▪ Availability of the right advice in the right place, first time; ▪ Responsive, urgent physical and mental health services outside of hospital at any time of day, every day of the week	▪ People supported to live independently for as long as possible ▪ Reduction in unplanned, avoidable admissions and reduced length of stay in acute hospital resulting in reductions (up to) 18% in total bed use within an acute care setting ▪ Substantial reduction in outpatient appointments in acute settings ▪ Patients dying in their place of choice	▪ Underpins our transformation model and is core to future delivery of integrated care ▪ Individuals supported to manage their own conditions and stay well as much as possible ▪ Improved system performance, across A&E, RTT and financial efficiency
Year 1 Priority	▪ Define operating model for UCCs, including an STP wide service specification ▪ Review current services and work with providers on rapid action plan to improve, or identify need for retendering ▪ Oversee implementation of plan to agreed timescales (within year 1/2)	▪ Implementation at pace in ESBT and learning to be shared, including proactive care, integrated locality teams and personal resilience schemes ▪ Agree STP-wide principles for implementation ▪ Coordinate with hospices, third sector and voluntary organisations	▪ Complete design of primary care models to deliver the GP 5YFV and ten high impact changes ▪ Ensure implementation trajectory to enable pace of plans – i.e. new models implemented for all practices no later than 2017/18

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Our STP plan for this winter

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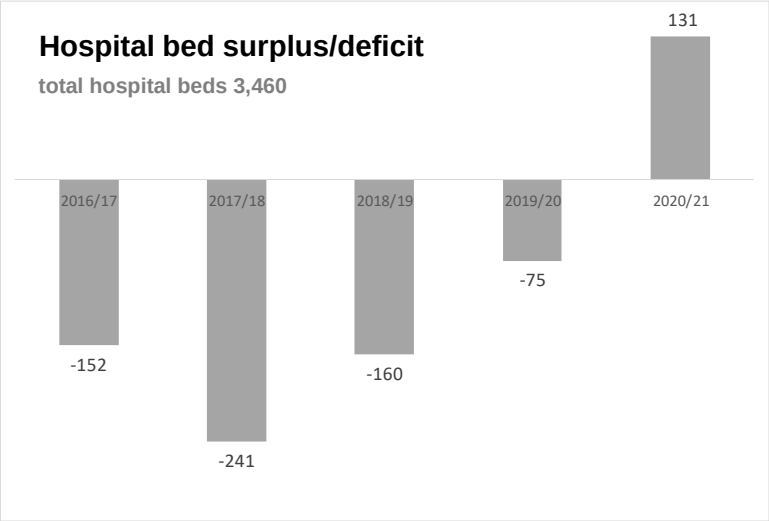


Our challenge

We have an immediate capacity shortfall (of around 3% of hospital beds) that we think will continue, and peak, next year, before our "person-centred" models begin to change the number of hospital beds needed.

There are three hospitals that will face particular pressure, Brighton (Royal Sussex County site), Eastbourne, and Hastings.

We have worked together as an STP to explore opportunities to make best use of space at existing hospitals. We have worked in partnership with social care and community providers, and have found alternative beds where patients no longer need medical care but aren't yet ready to return home.

Our solutions

We have developed an immediate action plan, summarised below, and are continuing to develop further opportunities as an STP, both to mitigate any under-delivery and to prepare for next winter.

Immediate actions:

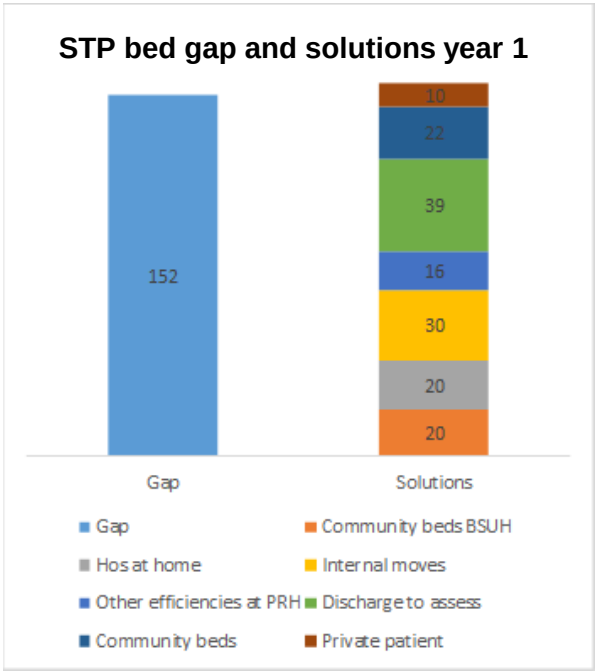
At RSC in Brighton: 20 beds at a community site: with a nursing model and active management of capacity for rapid discharge, 20 beds through "Hospital at Home" expansion: focussing on improving quality of care for this cohort of patients, rather than making them wait in acute beds for rehab, and 30 beds through internal movement of services and better use of existing estate

For Eastbourne and Hastings: 39 community beds through the "discharge to assess" programme where patients do not need to stay in hospital but don't yet have the support to live at home, 22 additional beds opened in existing community hospitals that were closed over the summer, and10 beds internal movement of services and better use of existing estate

Subsequent actions requiring further planning:

The STP will monitor fortnightly and accelerate any plans if additional risks come to light or there is any unexpected surge in demand.

The additional actions being explored include: Identification of a small number of tertiary services that could be temporarily diverted to relieve pressure, new models at the front door, conversion of non-clinical space, extension of use of community beds and building temporary beds.



*After adjustments for unmet demand, target occupancy and winter surge capacity.
Sources: Modelling by 2020 Delivery, based on BSUH 3Ts model and EY Benchmarking 2015. Beds from national sitrep data; growth and impacts of place-based care and prevention from STP financial model

Long term provider sustainability (2-5 year plan)

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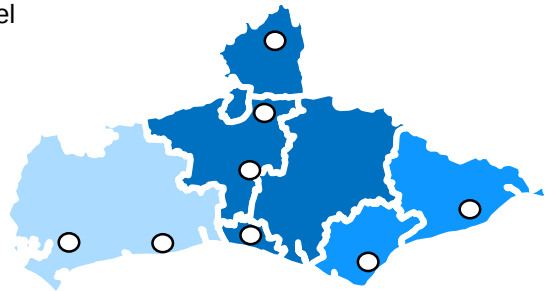
Acute sector sustainability challenge

- Within our STP we have a history of collaboration and successful networking around a range of specialist and tertiary services, including vascular, stroke, cancer and others.
- We recognise that our place-based, integrated plans will mean that patients will less frequently need to travel to hospital for care, and are built upon an increase in primary care and community care capacity.
- Opportunities through improved digital technology will allow further networking of services, with doctors in one hospital able to provide support and input to the team caring for a patient in another part of the patch, however there will remain a mis-match in available capacity and local demand between our sites,
- We also have a significant financial sustainability challenge in our acute sector, which may increase if services change but the model of provision and care pathways do not evolve at sufficient pace.
- We are now considering how we work together as an STP to support individual organisations around DGH services that we believe will become unsustainable over time. This work is about extending and furthering the existing networks and collaboration across the patch.
- We recognise that this discussion also needs to link with the outcomes of the NHS England led work assessing the requirements and sustainability for an MTC at RSC in Brighton, alongside teaching and tertiary services



Our acute sustainability solutions

Short Term → **Medium Term**

Elective care collaboration: partnership discussions are underway between hospitals
Specialised transformation: work closely with Specialised Commissioning on transformational QIPP schemes in addition to successful completion of MTC review at BSUH
Efficiency: pathology and imaging collaboration
Networks: working together to design how we will work as an STP on networked DGH services
Alignment with person-centred care: networking with local urgent care centres
for quality of care

Elective factory: further develop scope to reduce waiting times and increase efficiency
Alignment with ACO Models: our providers participate in our ACOs in different ways, but we intend to maximise access and use of services at all sites including for integrated care models
Complete the detailed design and implications of our future networked model to deliver sustainability as an STP

Brighton hospital re-development underway: working through networks with other providers and with underpinning specialised services model to support complete
Patient pathways for all sites mapped and delivered: through networks across sites and providers
Whole system performance transformed: aiming for top quartile nationally

Financial position by 2020/21

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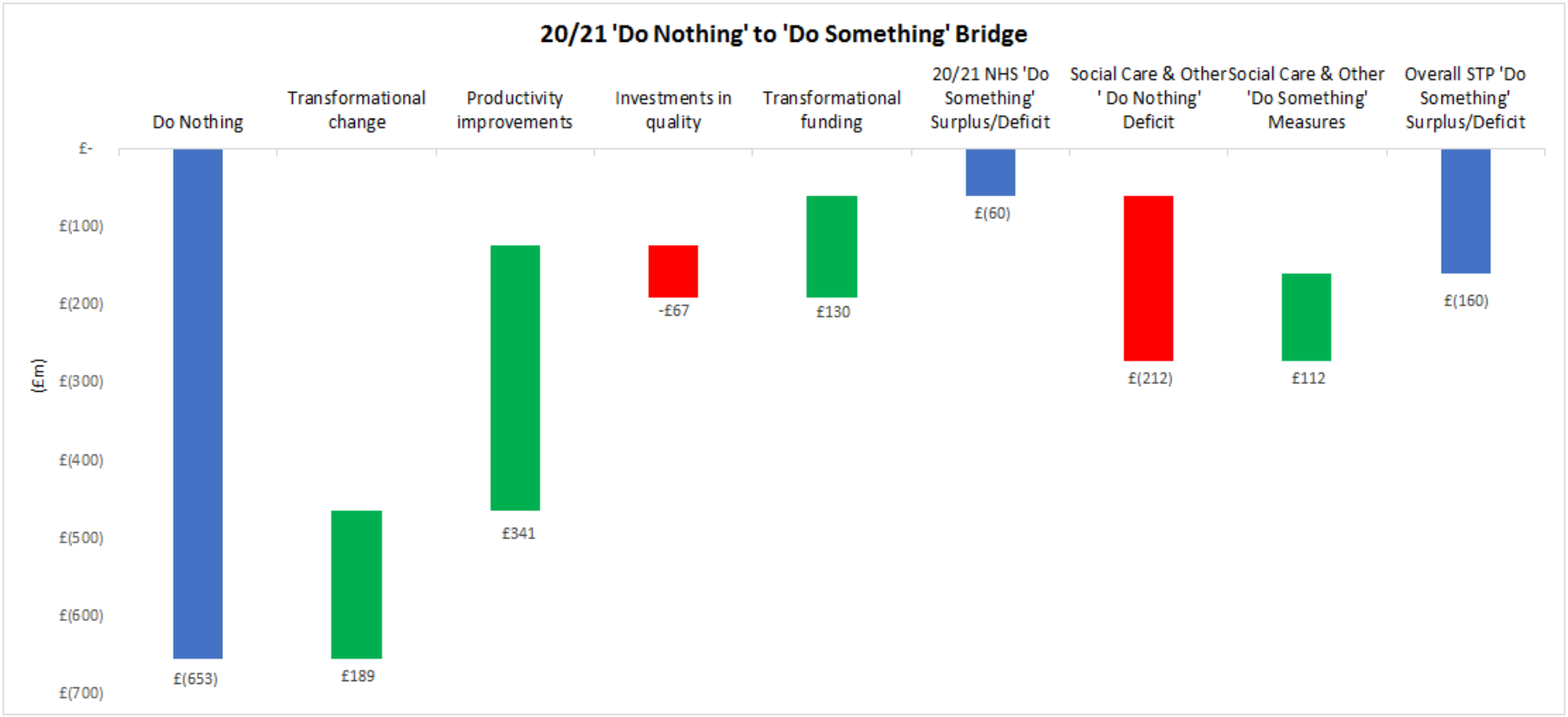


- Our financial plan includes £530m of net savings across the NHS resulting in a residual deficit of £60m
- An additional £112m of social care efficiencies have been identified. We continue to work with colleagues in LAs to understand and develop a response to financial pressures they face and how we ensure our plans effectively mitigate this too
- Our plan includes £140m of recurrent investment in quality by 20/21 to deliver the service improvements outlined in the NHS Five Year Forward View (£73m is in the “Do Nothing” position and £67m is shown above)
- In addition to a £450m transformation of the Royal Sussex County Hospital site, we are planning a number of strategic capital projects to develop the estate and digital infrastructure that our transformative new models of care need to thrive (see appendix D3)

Integrating mental health with physical health across our footprint

Our June submission highlighted the case for change across the footprint and since then we have created a Mental Health Review team to ensure each place-based plan delivers the MH5YFV . In managing the challenges of the years ahead, the **integration of mental and physical health** is at the core of our wider strategic thinking, enabling opportunities to co-design and improve access to care and treatment that is holistic, timely, of a high quality and delivered in an appropriate non stigmatising setting. The footprint is committed to ensuring that the investment identified for mental health is spent on addressing the priorities identified in the MH5YFV & Transforming Care for People with Learning Disabilities and where there are gaps in service provision and variation in practice and outcomes across Sussex and East Surrey.

Priority	Our future vision/what is going to be different?	Actions to be implemented
1. Specialist Services	Developing new models of care and integrated pathways which focus on early intervention and prevention to avoid Tier 4 inpatient admissions, support early discharge, treatment and repatriation as close to home as possible.	▪ To work with NHSE to establish Specialist Commissioning arrangements for: CAMHS Tier 4, Eating Disorders, Personality Disorders forensics & people with learning difficulties and expand perinatal mental health services ▪ To develop new evidence based pathways and models of care that support admission avoidance and reduced lengths of stay.
2. Integration of Mental Health with Physical Health	Co-designed networked operating model developed with each place based plan & local populations that connects across the wider health and social care system, embedding the principles of integrated mental & physical wellbeing and providing a seamless interface with primary, acute and out of hospital care services and a 'no wrong door approach.'.	▪ Explore New Care Models that support the integration of mental, physical and social care across the system. ▪ Co-design a connected networked model for mental health that provides a seamless interface for people of all ages and levels of ability, exploring options for integration, single point of access, co-location, estates optimisation, common & shared governance, & outcomes. ▪ Implementing Making Every Contact Count Training across the whole workforce
3. Gaps in Primary Care Provision	Improved access and availability of mental health knowledge and expertise in primary care to include early diagnosis and treatment of people with dementia & long term conditions and improved access to holistic care for people with mental health and / or a learning disability	▪ To explore evidence based approaches that support good physical & mental health and wellbeing in primary care including: increased access to IAPT across long term conditions & integrated with physical healthcare; increase in dementia diagnosis rates. ▪ Establish primary care pilots during 17/18 e.g. to co-locate integrated mental health within GP services & expand Sussex Youth service model (i-Rock) ▪ Build on Dementia Crisis team in Coastal W. Sussex and Golden Ticket in High Weald Lewes & Havens and rolling this scheme out wider across the footprint by 17/18. ▪ Build on learning of Technology integrated Health Management (Dementia) Innovation Test Bed.
4. Citizen Led Prevention and self management	We will create resilient communities and engage citizens in activities that improve awareness & understanding of the psychological determinants of ill health including factors that underpin poor lifestyle choices.	▪ Develop in-reach emotional wellbeing support to the PHSE syllabus in schools by exploring and providing actual & virtual initiatives ▪ Implementing MECC across the whole health & social care workforce ▪ Expand Recovery College & Social Prescribing models.
5. Managing Crisis Well	People experiencing mental health crises will have rapid access to a range of well coordinated community care options and high quality inpatient provision, supported by an effective Crisis Care Concordat, that will impact on the wider system by reducing pressure on acute services, reducing non elective admissions, attendances at A&E and lengths of stay and provide opportunities for estates optimisation.	In 17/18 commit to develop and invest in a range of approaches to address gaps in quality & service provision: ▪ Expand evidence based Psychiatric Liaison model ▪ Expand model of Crisis Response & Home Treatment 24/7 ▪ Implement Single Point of Access for Urgent and Crisis Care ▪ Expand out of hospital networks of support e.g. Safe Haven model & Street Triage ▪ Review quality and capacity for acute inpatient and intensive care services
6. Increase Digital maturity & Shared Digital Record	There will be full interoperability of healthcare records across the health & care system that supports people in telling their story only once. We will have developed a digitally competent workforce.	▪ Implement integrated care records through the Digital Road Map. ▪ Identify training and development needs of the workforce to embrace new healthcare technologies that create efficiencies and improve quality of care.

WORK IN PROGRESS

Digital transformation plan

WORK IN PROGRESS

Digital is a key enabler of our STP. In learning from the past we are proposing a multi track approach to Digital development that we believe will deliver the best outcome for the Citizen and the Health and Care professional. In parallel we are responding to feedback from NHSE on the detailed elements of our Local Digital Roadmap. With significant central finance available to support Digital Transformation we will build detailed plans to maximise benefit to citizens and staff.

Strategic approach

Digital Solutions that most benefit from scale in terms of procurement, cost, and integration capability, are implemented at STP level, not separately within each Place.

Integrate the Digital Team with the priority care pathways to support digitisation of both the professional and citizen journey

As the Place based models mature we will develop solutions by place that can best meet the business requirements. These developments will be subject to STP Digital Goverance to ensure we balance speed with efficiency

Proactively engage with Health & Care professionals.

We will explore the value of using resources more effectively at a Place and STP level to deliver the most financial and service benefit.

Priorities

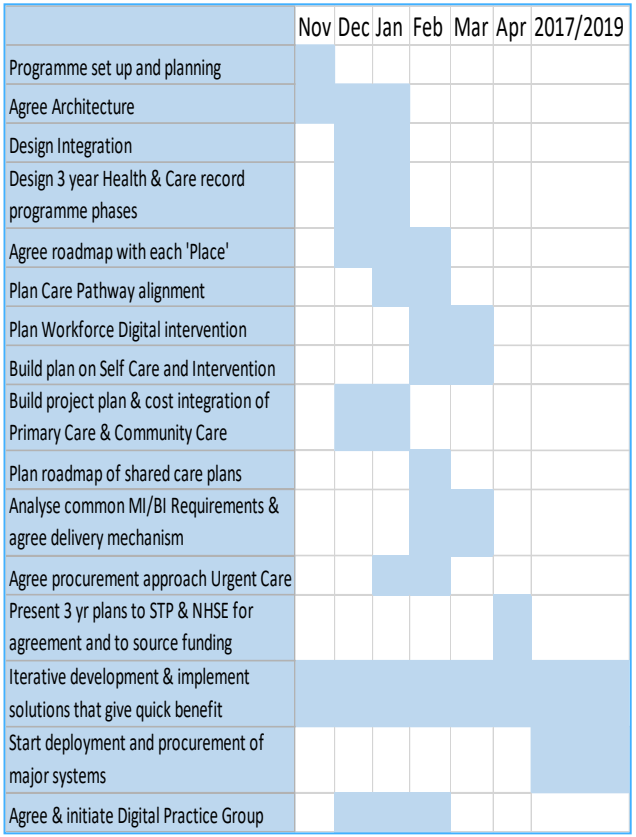
STP Wide

- Shared Digital Care Record (Physical & Mental Health, Community & Social Care).
- Urgent Care technology as part of the 111 procurement.
- Shared Infrastructure.
- Importing learning from other footprints E.g. Digitisation of Cancer Pathways.
- Supporting Workforce work stream in secondary care resource optimisation
- Health & Social Care Practice Group

Place Based

- Consolidation of Primary Care Systems and integration with Community Care Systems.
- Shared Health & Social Care, Care Plans.
- Development of operational technology to run the Place based systems . Analytics to enable Place based performance measurement.
- Prevention and self care technology
- E Consultations
- Interactions between Secondary & Primary Care

Programme Plan

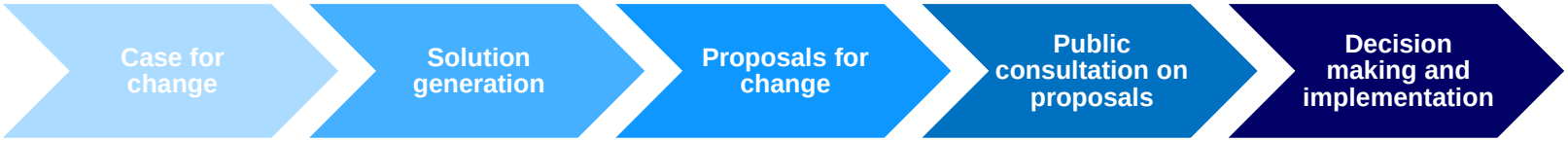


Continuing to engage our population: our patients, the public, our workforce, and our culture

WORK IN PROGRESS

- We believe passionately that public/patient engagement is not just a duty; but the pre-requisite for effective service improvement; from collectively identifying problems and designing solutions to influencing delivery and review.
- Our communications and stakeholder engagement plan is a working document that is being crafted and updated to fully exploit all existing communication channels to promote and continue an ongoing conversation with everybody who uses our services; including those people who live outside of our area.
  - It will focus on a wide range of channels to encourage wide community engagement; including digital; face to face and printed materials.
- Our primary aim is to design people-centred methods of engagement to match the needs of individual groups in the area and to ensure that we draw in views from people whose voices are seldom heard and those representing people with protected characteristics.
- In addition to the broad engagement activities we acknowledge that a number of our organisations have significant cultural issues, in some instances signalled by the CQC, and forming part of regulatory action. We will roll out an STP wide change management and performance improvement approach built on Virginia Mason principles, and catalysed by our two providers who have participated in the national pilot scheme.

Stages for STP Engagement



- We are working closely with our colleagues in health and social care, and via Healthwatch, to ensure that our plans are built on insights and conversations around patient experience and service needs and expectations.
- The heart of our approach will be centred on continuous dialogue; however we will closely monitor all emerging plans and seek legal input, and test with our overview and scrutiny committee, to ensure that we fully comply with legal guidance on more formal consultations.
- We will adopt a fully transparent and open approach to our community re all changes; not just to ensure that we adhere to the checks and balances in the system but because we truly believe this process provides us all with a unique opportunity to design a strong, effective health service that will meet both our needs and those of the generations to come.
- Everybody with an interest in our health service will be invited to join our conversation.
- We will continually update people on progress of our Comms and Engagement plan and there will be a clear audit trail of the activity that has taken place; including questions raised and responses to them.

What support do we need to ensure that we are able to deliver?

WORK IN PROGRESS

Financial

- Support transition funding to manage capacity and activity during build of 3Ts project, for BSUH and other sites in the STP
- To secure both support and agreed funding on the 16/17 BSUH and ESHT winter recovery capital ask as signalled in both organisations' recovery plans and their respective summaries contained in Appendix C of this document
- We recognise the tight position on national NHS funding. We have a number of challenged organisations in our STP. As part of the support that we require from the Centre we would propose that careful consideration is given to the overall control totals that are set in the first two years of our plan. Our goal is to achieve financial sustainability over the five year period, but given the heavy deficit position which is our starting position we will find it very difficult to achieve current control totals in the first two years.
- Guidance on how delivery of large scale transformation and long terms savings should be balanced against very challenging short term financial targets, surrounding both revenue and capital
- We would like to register the need for appropriate funding for investment in integrated care record systems for which plans will be forthcoming by the end of the calendar year

System Leadership

- Support in delivering commissioning reform as signalled in our place-based plans
- Support the STP to have the authority to deliver sustainability and improvement actions as a whole system

System Recovery

- Assistance in balancing the need of specialised commissioning with local delivery of safe care and constitutional standards, particularly in relation to the immediate challenges at BSUH and the long term vision for that site

Appendices

Glossary: Acronyms used

Acronym	Meaning
ACO	Accountable care organisation
CIP	Cost improvement programme
CSESA	Central Sussex & East Surrey Alliance
ESBT	East Sussex Better Together
MECC	Making Every Contact Count
MCPs	Multi-speciality community provider
MTC	Major trauma centre
PACS	Primary and acute care system
RSC	Royal Sussex County (Hospital site in central Brighton)
RTT	Referral to Treatment
SPoLs	Single Points of Leadership (one for each Place)
UCC	Urgent Care Centre

Contents of appendices

a) Governance

b) Place-based delivery plans – CSESA, Coastal, ESBT plans **(in separate document)**

c) Acute recovery plans **(Detailed plans contained in separate document)** –
   i. Summary BSUH Winter Sustainability Plans
   ii. Summary ESHT Winter Sustainability Plans

d) Finance

e) Workforce

f) Specialised Commissioning

g) Achieving savings through environmental sustainability

h) Summary of cancer and stroke improvement priorities

Appendix A.1: STP Governance

WORK IN PROGRESS

Programme groups

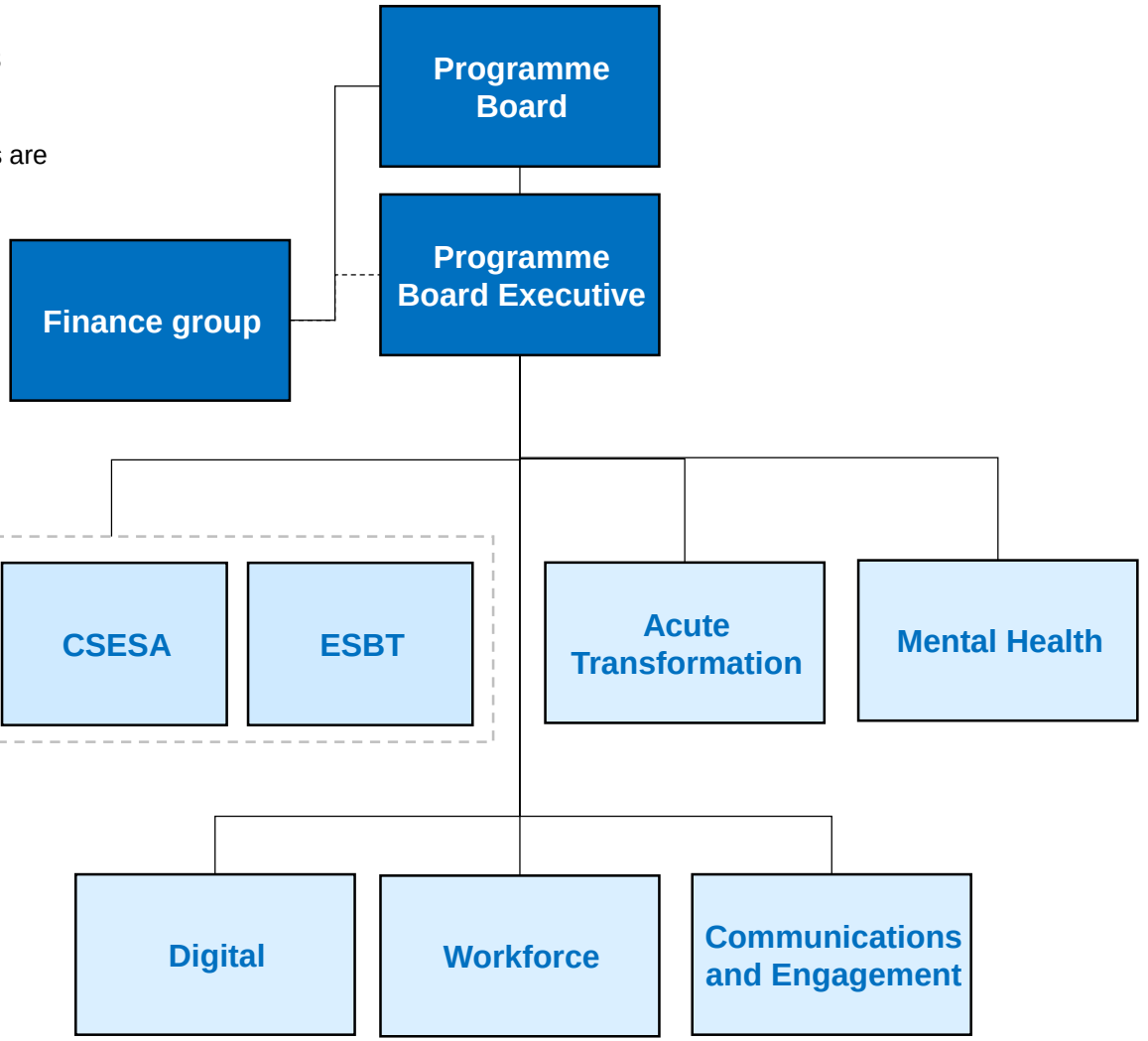
- Programme board has representation from all 23 STP organisations
- The Programme Board Executive is led by the leaders of our three places to ensure local needs are at the heart of our planning
- The Finance workstream is a "sub-group" of the programme board, with representation from all organisations, to provide robust information for planning

Core workstreams

- Each place is responsible for patient-centred care models
- Collaboration between streams are facilitated by the Programme Board and Executive

Enabling workstreams

- Membership include three places, acute, mental health, plus other "experts", e.g. HEE in workforce
- Each group have built on existing networks, e.g. communications and engagement working through the existing acute communications group



Appendix A.2:
STP Executive Group – Purpose and Principles/Behaviours

WORK IN PROGRESS

An Executive Group has been established to drive delivery of the STP.

Purpose of the STP Executive Group:

The purpose of the Sussex and East Surrey STP Executive Group is to oversee and drive the implementation of pan-STP decisions on behalf of the population served by the 23 member organisations. In addition, the group facilitates place-based progress/accelerate to achieve overall transformation of the STP footprint/5YFV triple aims.

The following principles/behaviours will apply to the model:

1. All organisations are signed up to the STP, its targets and delivery plan.
2. The **Executive Group** will deal only with those issues which are best considered on a pan-STP basis.
3. **Place-based "single points of leadership" (SPOLs)** will deal with their local place-based issues through their local governance.
4. Each member organisation retains its own Governance authority and accountability to its Board of Directors in line with current organisational form.
5. The **Executive Group** facilitate collaboration and cooperation across its membership in the interests of the population served. Where individual Boards do not agree with proposed plans, it is the responsibility of the **place-based SPOLs** to resolve locally or identify a range of options for negotiation at Programme Board.
6. Place-based responsibilities are the role of the SPOLs. Local governance should approve SPOLs to act on behalf of their Place at Executive Group.
7. Boards of all members will be responsible for agreeing recommendations and no-gos in order to support the single system leader in their decision making .
8. Decisions will not be taken that totally destabilise one partner.
9. No single organisation will halt the progress agreed by all the other place-based or STP partners.

Membership of the STP Executive Group:

Chair – Michael Wilson, *Chief Executive, Surrey & Sussex Healthcare NHS Trust*
SRO – Wendy Carberry, *Chief Officer, High Weald Lewes Havens CCG*
Coastal Care SPoL - Marianne Griffiths, *Chief Executive, Western Sussex Hospitals NHS Foundation Trust*
CSESA SPoL - Geraldine Hoban, *Accountable Officer, Horsham & Mid Sussex CCG*
ESBT SPoL - Keith Hinkley, *Director of Adult Social Care & Health, East Sussex County Council*
Siobhan Melia, *Chief Executive, Sussex Community NHS Foundation Trust*
Colm Donaghy, *Chief Executive, Sussex Partnership NHS Foundation Trust*
Dr Minesh Patel, *Chair, Horsham & Mid Sussex CCG*
Steve Emerton, *Director of Delivery, NHS England Specialised Commissioning STP South East*

Appendix B: Place-Based Delivery Plans

Please note: the Place-based Delivery Plans are contained in a separate document.

Appendix C.1: Winter sustainability plans

WORK IN PROGRESS

Please note: Winter sustainability delivery plans are contained in a separate document.

Appendix C.2:
BSUH acute winter sustainability plan 2016

WORK IN PROGRESS

Total gap at RSC site in Brighton is 66 beds. The current actions to solve this issue are:

Solution description	Beds saved*	Milestones for implementation	Risks/Implications	STP assessment of delivery risk and key mitigations
Agreement across STP has been reached that additional capacity is needed – community beds	20 (17)	10/16 - Lease agreement & pathways 11/16 – staffing complete	• Staffing • Impact of step-down beds on acute beds (not 1:1 due to ALOS)	The model will only work if sufficient focus is maintained on keeping length of stay down by getting people discharged promptly. This may need additional focus, e.g. through daily monitoring/escalation in partnership with LAs
Hospital at home	20 (15)	17/10/16 – expand capacity to 8 patients 11/16 – expand to 20 patients	• Staffing for expansion, particularly if any acceleration is required	The workforce to deliver this model overlaps with that for a number of other schemes and so will need STP-wide coordination
Moves off-site (primarily to PRH site)	4 (4) 4 (4) 8 (6) 10 (8) 2 (2) 2 (2)	Balcombe wards – 11/16 Sussex rehab beds – review staffing 10/16 Use of Allbourne – TBC Oncology SOTC bays Spinal Infusions at HWP	• Staffing • 30 day consultation for Oncology and Spinal	Risks are primarily in deliverability and thus felt to be manageable
Total solutions	**70 (58)**			
Total indicative cost^	**£1m**	^ BSUH received support from NHSE/I on 19th October 2016 for this winter recovery plan		

The STP is supportive of BSUH's plan to develop a number of additional potential solutions that will be worked up in parallel to mitigate for any slippage. These actions include: identification of a small number of tertiary services that could be temporarily diverted to relieve pressure, Hospital at Home at front door, conversion of non-clinical space, extension of use of community beds and building temporary beds. The combined scale of these actions before risk adjusting is of the order of an additional 60+ beds.
The STP will monitor fortnightly and accelerate any plans if additional risks come to light or there is any unexpected surge in demand.

* Risk adjusted number
Source: BSUH plan

WORK IN PROGRESS

Appendix C.3:
ESHT acute winter sustainability plan 2016

Total gap at ESHT is 66 beds: the current actions to resolve this are:

Solution description	Impact – on beds	Milestones for implementation	Risks/Implications	STP assessment of delivery risk
Hastings site				
Discharge to assess nursing home beds	19	Already commissioned with CCG and agreement with SC. Staffing will be covered by nursing home	• Impact of step-down beds on acute beds (not 1:1 due to ALOS) • Mitigation in ESBT "operations room"	The model will only work if sufficient focus is maintained on keeping length of stay down by getting people discharged promptly
Rye Memorial hospital	5	Beds owned by trust, staffing planning taking place 13/10	• Impact of step-down beds on acute beds (not 1:1 due to ALOS)	Risks are primarily in deliverability and thus felt to be manageable
Eastbourne site				
Discharge to assess nursing home beds	20	SC working with CCG 13/10 – beds already identified	• Impact of step-down beds on acute beds (not 1:1 due to ALOS)	The model will only work if sufficient focus is maintained on keeping length of stay down by getting people discharged promptly
Private unit beds	10	Agreement in place for beds	• Staffing – recruitment required	Requires coordinated recruitment approach
Seaford 2 beds	17	Beds owned by trust, staffing planning taking place 13/10		Risks are primarily in deliverability and thus felt to be manageable
Total solutions	**73**			
Total indicative costs	**£2.89m**			

Source: ESHT plan

WORK IN PROGRESS

Appendix D.1:
Financial challenge in intervening years

	2016/17 FOT	2017/18	2018/19	2019/20	2020/21
Do Nothing NHS Position	**£ (47,639)**	**£ (310,599)**	**£ (421,720)**	**£ (541,690)**	**£ (653,490)**
Investing for Quality‡					
Seven Day Services		£ -	£ -	£ (3,811)	£ (38,114)
Cancer Taskforce		£ (5,820)	£ (7,060)	£ (8,403)	£ (9,573)
National Maternity Review		£ -	£ (4,570)	£ (4,573)	£ (4,576)
Digital Roadmaps		£ (3,600)	£ (7,200)	£ (10,800)	£ (14,400)
Sub-total		**£ (9,420)**	**£ (18,830)**	**£ (27,587)**	**£ (66,663)**
Place-based care†					
Community – based investment		**£ (13,553)**	**£ (21,838)**	**£ (30,204)**	**£ (38,394)**
Acute Savings		£ 51,733	£ 96,434	£ 135,314	£ 171,021
Sub-total		**£ 38,180**	**£ 74,596**	**£ 105,110**	**£ 132,628**
Further Efficiencies					
Prevention		£ 6,946	£ 14,029	£ 21,243	£ 28,670
Provider Productivity		£ 64,769	£ 132,078	£ 202,242	£ 276,215
Medicines Management		£ 8,685	£ 17,736	£ 27,151	£ 36,945
Specialised Commissioning		£ 14,651	£ 26,756	£ 40,275	£ 55,734
Sub-total		**£ 95,052**	**£ 190,599**	**£ 290,911**	**£ 397,563**
CCG Surplus replenishment*		**£ (24,733)**	**£ -**	**£ -**	**£ -**
Transformational Funding		**£ 49,176**	**£ 49,176**	**£ -**	**£ 130,000**
Do Something NHS Position	**£ (47,639)**	**£ (162,343)**	**£ (126,179)**	**£ (173,257)**	**£ (59,962)**

- Despite our plans achieving significant progress by 20/21, there exists a stark financial challenge across years 2- 4 of the STP, driven by a starting deficit, increasing demand pressures and a time requirements associated with mobilising new place-based models of care
- As a result, our plan does not meet control totals for 17/18 and 18/19, but we remain committed to identifying further opportunities to improve our position and reduce the gap
- ‡Additional investments to deliver the GP Forward view (£51m by 20/21), and Mental Health Taskforce and CAMHS (£18m by 20/21) are included in the Do Nothing baseline
- †The level and phasing of place-based savings is different across the 3 places, as outlined in appendix D.2
- *The current conservative assumption a £25m non-recurrent requirement to replenish all CCG surpluses in 20/21

WORK IN PROGRESS

Appendix D.2: Capital expenditure projects by Place and category

- Each place is planning investments in it's communities to ensure the impacts on acute demand growth and population health are delivered
- Acknowledging the shortage of centrally-held capital, we are planning an innovative and diverse range of capital sources

Place	STP-wide solutions	Enabling out of hospital care	System Resilience	IM&T	TOTAL
CSESA	-	£175m	£70m	£32m	£277m
Coastal	£17m	£67.5m	£20m	£10m	£114.5m
ESBT	-	£50m	£35m	£15m	£100m
TOTAL	**£17m**	**£292.5m**	**£125m**	**£57m**	**£491.5m**

Source: Place based capital plans

Appendix D.3: Potential capital sources by project category

WORK IN PROGRESS

Category	Project	Value £m	Source	
System resilience	BGH Reconfiguration	20	PDC and DH loans	Required to ensure quality of service and outcomes are protected
	East Sussex BT alignment of acute	35		
	Western Ward Block	20		
	Pathology network	15		
	Rapid diagnostic centres	30		
	A&E reconfiguration Royal Sussex	5		
	Reconfiguration of PRH	TBC		
	TOTAL	**125**		
Enabling out of hospital care	Crawley, Horsham and Mid-Sussex Community Hubs	165	Commercial capital partnerships & commercial loans	Required to underpin new person-centred, integrated models that deliver care in community settings, reduce acute demand and improve population health
	Southlands Ambulatory hub	20		
	Littlehampton Community Hub	12.5		
	Worthing Civic Quarter Community Hub	16		
	Shoreham Community Hub	12		
	Bognor Community Hub	2		
	Durrington Community Hub	5		
	East Sussex Community Hubs	10		
	Preston Barracks community hub	TBC		
	ESBT Community hubs	50		
	TOTAL	**292.5**		
STP-wide	LDR capital projects	**57**	LDR bids	Key STP strategic enablers
	Western Radiotherapy unit	**17**	Commercial capital partnerships & commercial loans	
Total		**491.5**		

Source: Place based capital plans

Appendix E.1:
Strategic Workforce Plan

WORK IN PROGRESS

- The Sussex and East Surrey Sustainability and Transformation plan has developed a workforce strategy to deliver the transformation required to serve the needs of our population.
- The challenge for the workforce programme is to address the immediate problems and support the plans for winter pressures, whilst developing the strategic solutions for a sustainable future.
- The STP has set up a Local Workforce Action Board to lead and implement the workforce strategy to support the STP. The Board is Co-Chaired by Richard Tyler CEO of Queen Victoria NHS FT and Philippa Spicer the HEE Local Director and its membership includes representation from the new 'Places' together with clinical leadership and commissioning
- HEE is providing programme management, and resource to ensure that the actions, particularly the priorities, will be implemented. An allocation of £1.3m has been identified to support the implementation of the LWAB action plan. These funds are being are being distributed to meet the needs of the priority task and finish groups. A further allocation of £460k has been funded through the Community Education Provider Networks (CEPNs) within the STP footprint.
- N.B. The Acute recovery plans are dependent on workforce being able to support the plans that have been put together to ensure Acute sustainability through 16/17. Without a coordinated focus from both the workforce subgroup and the organisations involved, the plans are at risk. All providers are relying on the same pool of staff and so this will require coordination. That said, plans are in place with specific providers such as 130 nurses in pipeline at one provider and international recruitment being reinstated due to the success of the previous scheme.

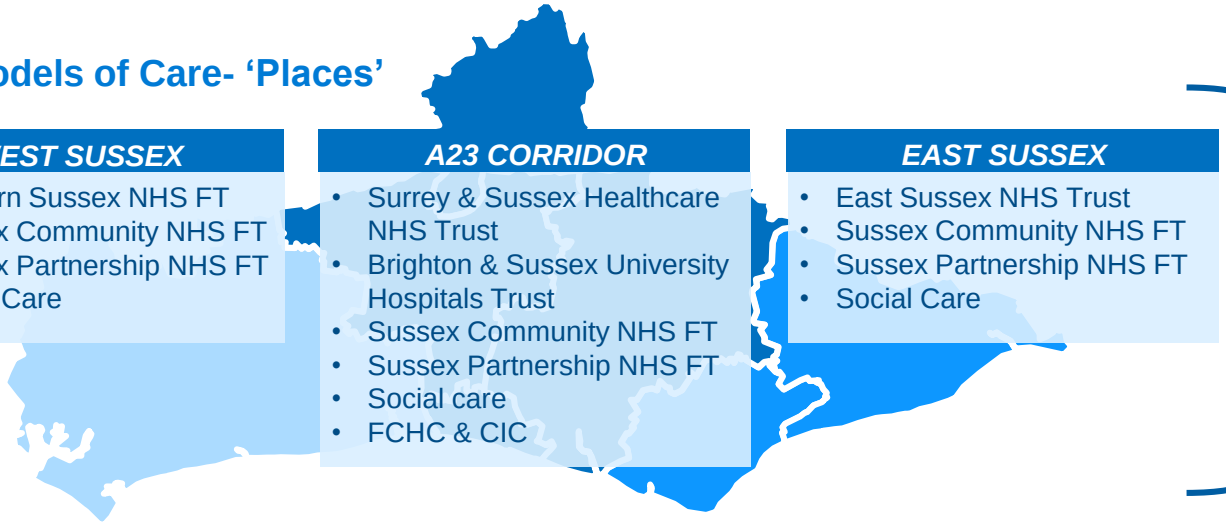
The LWAB has held several stakeholder events to develop an action plan to meet the requirements of the STP. Meetings on the 25th July and 30th September have helped to shape this work, building on existing work, identified challenges and key priority areas that have been highlighted through stakeholder engagement sessions, which have included all organisations, both health, social care, PVI, Education and Trade Unions. The plan has pulled together the actions from the June 2016 STP Submission and is grouped under five key areas within the 5YFV:

Workforce Action Plan / 5YFV	Priorities 2016/17
Prevention	MECC – Joint Programme with Public Health April 2016 – March 2017
New Models of Care	▪ Implementation of the WRaPT Workforce Repository/Planning Tool. – East Sussex Better ▪ Together and Brighton Hospital at Home. Proposal and resource agreed by STP. Mobilisation meeting on X date
System Wide – Effective & Efficient	▪ Temporary Staffing – Agency Programme in place, implementation by March 2017 ▪ Locum Spend – Trend mapping underway to report to STP December 2016 ▪ Shared Functions – Skills Passport – programme agreed
Integration	▪ Proposals from 30th September stakeholder event being developed for implementation, e.g. Shared Therapy teams to support re-enablement and Cross care pathway role
Recruitment and Retention	▪ Retention programmes: newly qualified – e.g. common preceptorship programme ▪ Mature workforce – Health and Well-being proposals. Paramedics retention ▪ Recruitment – Pre- Employment Coordinators. Prince's Trust programmes, Health and social care careers events etc.

WORK IN PROGRESS

Appendix E.2:
Strategic Workforce Programme

New Models of Care- 'Places'



WEST SUSSEX
- Western Sussex NHS FT
- Sussex Community NHS FT
- Sussex Partnership NHS FT
- Social Care

A23 CORRIDOR
- Surrey & Sussex Healthcare NHS Trust
- Brighton & Sussex University Hospitals Trust
- Sussex Community NHS FT
- Sussex Partnership NHS FT
- Social care
- FCHC & CIC

EAST SUSSEX
- East Sussex NHS Trust
- Sussex Community NHS FT
- Sussex Partnership NHS FT
- Social Care

LWAB IMPLEMENTATION PLAN BUDGET OF £1.8M provided by HEE

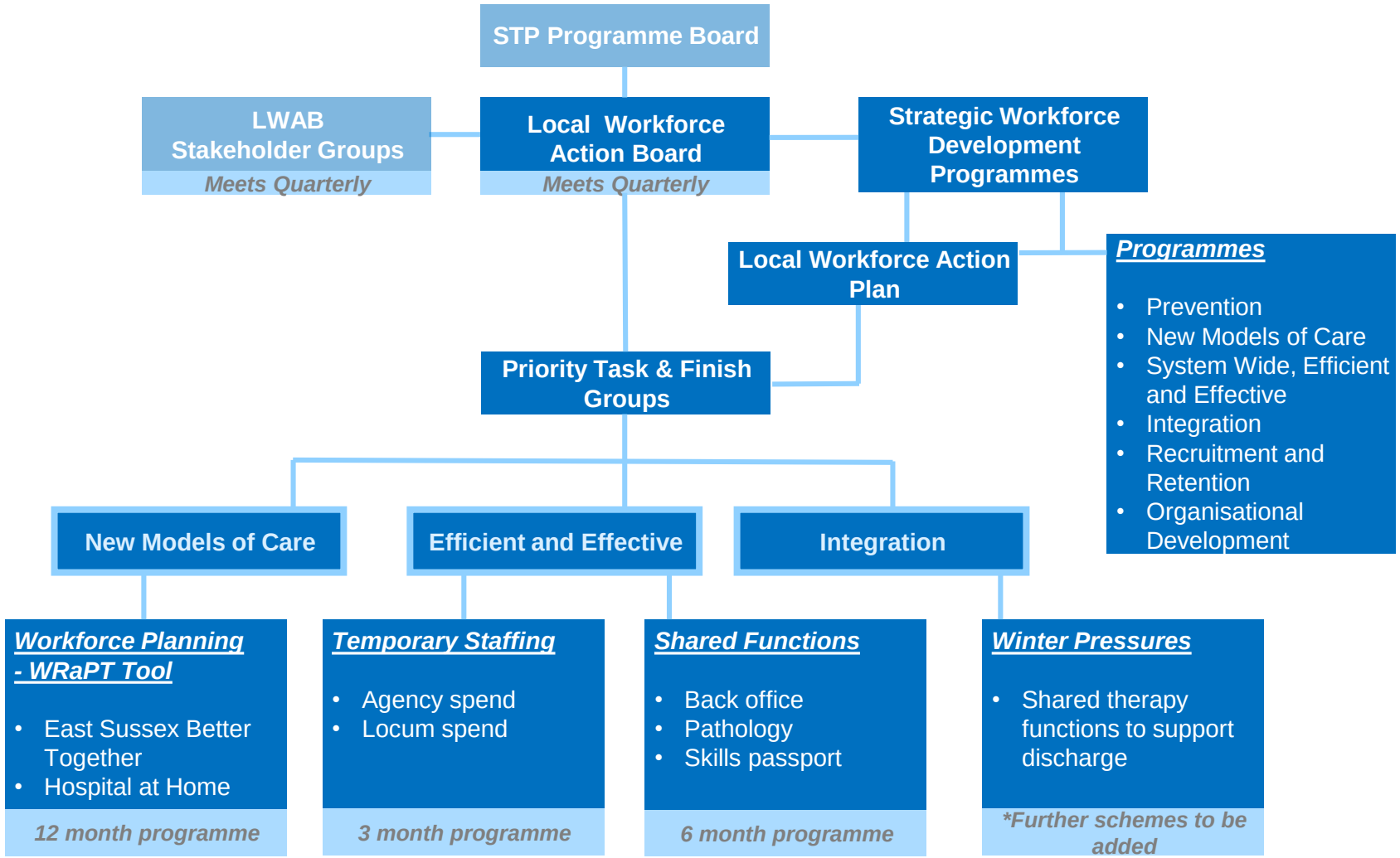
PRIORITY PROGRAMMES	**Temporary Staffing- agency and locums**		**Skills Passport**		**Winter Pressures- Shared Workforce (e.g. therapists)**			
PROGRAMMES OF WORK	Prevention	New Models of Care 'Places' WRaPT/OD	System Wide- Efficient & Effective		Recruitment & Retention		Integration	
DRIVERS	Shift to Primary & Community settings	Finance/ Pay Bill	Performance & Quality	Acute Pressures	Community Pressures	Mental Health Pressures	Primary Care Pressures	Social Care Pressures

The Workforce Action Plan is based on the need to transform the workforce for new ways of working in the future, whilst managing the immediate challenges of the workforce shortages and increased demand on services.

Diagram 1 shows the three 'places' within which the new models of care are being developed and which the workforce will need to work within. Diagram 2 shows the drivers for change and the programmes being undertaken

Appendix E.3:
Local Workforce Action Board – Governance

WORK IN PROGRESS



Appendix F.1:
Specialised Commissioning QIPP Schemes for 17/18

WORK IN PROGRESS

Transformational Schemes

Theme	Potential Transformational Schemes
Right Care	▪ Cardiology (links to pathway work below) ▪ Right care to look at work for Spec comm re MH, Neonatal and Cardiac ▪ Assessing timescales for outputs from " Getting it Right First Time" programme which may have implications for specialised services
New Models of Care	▪ Complex Cardiology pathway ▪ Cancer pathways (Inc. chemotherapy regimens) ▪ Neonatal – increasing proportion of term admissions ▪ Mental Health national 'New Models of Care- 2 pilots. Scope to roll out similar approach for CAMHS with SE as priority ▪ Assess scope for savings from current work on Vascular networks and Spinal pathways
Urgent & Emergency Care	▪ Enhanced supportive care – to reduce emergency cancer admissions
Self Care	▪ Opportunities re some neurological pathways
Prevention	▪ Secondary prevention re cardiology interventions (business case for project in preparation) ▪ Cancer ▪ Renal
CHC/Long term conditions	▪ Neuro- Rehabilitation pathways (to review scope for roll out of actions in SW)
Other productivity	▪ See Transactional schemes (on following slide) ▪ Ensuring effective planned care pathways (Inpt/ day case/ Daycase/ opt procedures
Cross Cutting Themes	▪ Critical Care – both transactional and transformational element s, focus on reducing length of stay ▪ Enhanced Supportive care (Inc. opportunities beyond cancer services) ▪ Peri-operative medicine Inc. Enhanced recovery and shared decision making with patients ▪ Repatriation – joint work with London to avoid unplanned changes of pathway but ensure appropriate, agreed pathway changes where appropriate.

Appendix F.2:
Specialised Commissioning QIPP Schemes for 17/18

WORK IN PROGRESS

Transactional Schemes

Theme	Potential Transformational Schemes
Medicines Optimisation* *Mix of full and part year effect	▪ Switch to generics and biosimilars – specific drugs to be identified together with phasing – and optimisation through ensuring more rapid take up ▪ Antifungal Stewardship – reviewing variation ▪ Starting and stopping criteria for MS drugs ▪ Intravenous immunoglobulin- best practice and reviewing database information which suggests variation in volumes being prescribed ▪ Effective prescribing of Antiretroviral Medicines – national tender ▪ Extension of SACT dose banding for chemotherapy and reducing chemotherapy wastage ▪ Home Parenteral Nutrition – recent national tender – reduction in associated costs ▪ Immunosuppressant repatriation (from CCG to NHS England for certain solid tumours) ▪ Optimising procurement opportunities ▪ Rationalise provision of aseptic units ▪ Review of outsourced pharmacies and in share arrangements ▪ Ensuring all PAS rebates secured ▪ Addressing variation in prescribing rates (links to population based prescribing work) ▪ Ensuring compliance with NICE pathways through individual patient tracking for certain high cost drugs
Reduced prostate fractionation	▪ Fye of scheme commencing Autumn 2017
Outpatients	▪ Mix of transformational and transactional elements- encouraging shift to non-face to face or lower costs appointments
Review of shared care pathways	▪ Mix of transformational and transactional elements- encouraging shift to non-face to face or lower costs appointments
Roll out of National Devices Procurement Scheme	
Continuation of CUR CQUIN	▪ To identify benefits of implementation
Price Benchmarking	
Neonatal	▪ ATAIN to follow clinical protocols to ensure consistent thresholds for referral to SCBU

Appendix G:
Achieving savings through environmental sustainability

CARE WITHOUT CARBON

A coordinated approach to carbon management within the STP

1. Context

Sussex Community NHS Foundation Trust (SCFT) has pioneered an innovative and award-winning approach to delivering sustainable, low-carbon healthcare called ***Care Without Carbon*** (CWC)**.** The CWC model successfully delivers value to the NHS by pursuing three complementary objectives:

1. **Carbon reduction** (measured in tonnes CO_2) – a measure of reduced environmental impact incorporating energy and water efficiency, waste management and travel and transport among other areas
2. **Cost improvement** – a reduction in CO_2 will almost always deliver a cost saving, for example through energy efficiency or travel avoidance
3. **Enhanced staff wellbeing** – a key focus for Lord Carter, CWC incorporates a strong staff engagement and organisational development element, aimed at encouraging behaviours that deliver not only cost and carbon savings but also help to support workforce wellbeing

The team behind CWC has developed a comprehensive approach to measuring and reporting on these outputs – most recently this has involved work with the New Economics Foundation to develop new metrics for measuring workplace wellbeing. Carbon management plans based on the CWC model are being developed for all the major provider organisations within the STP footprint and each has made commitments and plans to reduce emissions in line with NHS targets.

2. An SDMP (carbon management programme) for the STP

The STP's collective carbon footprint is estimated at 100,000 tonnes CO_2e per annum. This is primarily driven by energy consumption across the estate but it is also estimated the system produces over 10,000 tonnes of physical waste with staff driving over 20 million business miles each year. The cost of these impact s is estimated at £32M per annum and so carbon reduction presents a significant and tangible opportunity for cash-releasing savings.

Whilst individual Trusts have made commitments to reduce carbon, the STP offers an opportunity to deliver faster and more significant progress by taking a coordinated approach and achieving economies of scale in a number of key areas. As a key operational element of the STP, **a single, overarching carbon management plan will be produced** based on the CWC model, which will harmonise baselines, reporting and action planning on carbon reduction across services delivered in the STP. The plan will necessarily be closely aligned with the STP Estates Strategy and the CCGs' Local Estates Strategies and will be developed and implemented in parallel.

3. Implementation Plan

The CWC team at Sussex Community NHS Foundation Trust will lead on this work stream. Year 1 implementation plan tasks:

1. Review and merge organisational plans, creating overarching plan aligned with Estates Strategy, including harmonised baseline and targets
2. Establish five key sustainability work streams:
   - *i.* ***Utilities***: Options for driving energy & water efficiency across estate (including water industry deregulation options) and scope centralised Energy Bureau function. Investigate opportunity to create single investment vehicle to achieve cost and carbon savings across estate.
   - *ii.* ***Waste & Resources***: Assess potential for harmonised waste policy, targets and operational procedures, collective contract tendering and centralised Waste Bureau service to manage service
   - *iii.* ***Staff Travel:*** Scope opportunity for single Travel Transformation Plan to reduce staff travel time, cost and carbon across system and centralised Travel Bureau function to implement project work and support staff
   - *iv.* ***Commercial Transport*****:** Assess potential for consolidation of commercial courier services delivered by and provided to all STP organisations.
   - *v.* ***Culture****:* Assess opportunity to roll out successful staff engagement programme developed by SCFT to reduce costs, save carbon and improve workplace wellbeing
3. Assess additional resources and skills required to deliver work stream and create business case to secure necessary funding.

WORK IN PROGRESS

Appendix H.1:
Summary of cancer performance improvement priorities

Key drivers for change:

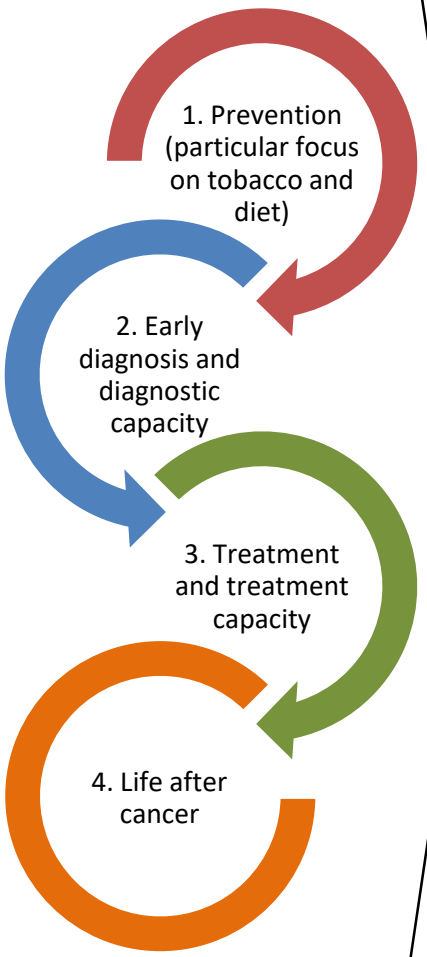
Performance:

- Poor historic one year survival rates, driven, for example, by lung cancer survival rates
- Poor historic rates of early diagnosis in particular tumour sites
- Trusts are struggling to deliver consistently on cancer waiting targets (in particular 62-day target)
- Below average patient experience of cancer services

Drivers of performance:

- High smoking prevalence in parts of the STP footprint (e.g., Brighton, Crawley, Hastings), high rates of obesity in some areas
- Growth in demand (especially for diagnostics), insufficient capacity in imaging, endoscopy, radiotherapy

Scope of end-to-end improvement initiatives:



Examples of specific improvements (detail to be developed Jul – Sept):

1. Development of "Rapid Access Diagnostic Centres" and pathways for symptomatic patients, ring-fenced from acute diagnostics, addressing shortfall of imaging and endoscopy capacity
2. Our "transforming care through our four localities" workstream includes a locally-driven focus on prevention and self-care in each locality, focused on tobacco, diet and exercise
3. Improving patient awareness of symptoms of potential cancers
4. Improving uptake on screening and vaccination, including:
    - HPV and cervical screening
    - Bowel screening (F.I.T. and bowel scope)
5. Exploring trial of GP direct referral for low-dose CT for patients at highest risk of lung cancer
6. Development of radiotherapy capacity (e.g., Eastbourne) and redevelopment of cancer centre as part of the 3Ts development at Brighton

WORK IN PROGRESS

Appendix H.2:
Summary of stroke performance improvement priorities

Area	Current performance of stroke services	Priorities for stroke improvements
Primary prevention of stroke	• Smoking prevalence high in parts of the STP footprint (e.g., Brighton, Crawley, Hastings) • Obesity prevalence is high in some of the same areas	• Implement the preventative activities related to tobacco, diet and exercise, that have been highlighted in the STP. This implementation to be driven via local place-based integrated care
Secondary prevention of stroke	• Detection and management of atrial fibrillation (AF) is critical to preventing strokes – performance across the STP area is currently mixed both as regards detection and management of AF • Detection and management of hypertension is important in preventing strokes – performance is poor in several CCGs	• Primary care-led implementation of actions to improve the detection and appropriate management of AF, including supporting patients to make an informed choice about which anti-coagulation is best for them, including considering of NOACs. • Improve the detection and management of hypertension
Treatment of TIAs and Acute Stroke	• Configuration of hyper-acute and acute stroke services not complete across: (1) Brighton/ Haywards Heath; (2) Worthing/ Chichester • Performance on "early assessment by specialist physician" is highly variable across CCGs	• Determine preferred configuration of hyper-acute and acute stroke services for each of (1) Brighton/ Haywards Heath; and (2) Worthing/ Chichester. The CCG Governing Bodies and HOSCs/HASC will then decide whether to implement a formal public consultation on these configurations, and, if appropriate, implement.
Rehabilitation and life after stroke	• Relatively poor performance on returning patients to their usual place of residence following stroke (4 CCGs statistically worse than peers) • Relatively poor compliance on physiotherapy and occupational therapy compliance vs targets	• For A23S and Coastal Care, Sussex Community Foundation Trust is meeting with each of the Acute Trusts and the CCGs to improve gaps in Early Supported Discharge and Community Neuro Rehabilitation.