Key Information

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 Foundation Trust
Contact details (email and phone): *Michael.Wilson@sash.nhs.uk*, 07768 376664
Organisations within footprints: We have included organisations below, grouped by the place-based plan they support, based on a 90% / 90% overlap of commissioners and providers:

A23 North	Coastal Care	A23 South	East Sussex Better Together
East Surrey CCG	Coastal West Sussex CCG	Brighton & Hove CCG	East Sussex Healthcare NHS Trust
Crawley CCG	Sussex Community NHS Foundation Trust	High Weald Lewes Havens CCG	East Sussex County Council
First Community Health & Care	Sussex Partnership Foundation NHS Trust	Brighton & Hove City Council	Eastbourne Hailsham & Seaford CCG
Horsham & Mid Sussex CCG	West Sussex County Council	West Sussex County Council	Hastings & Rother CCG
Queen Victoria Hospitals NHS Trust	SECAmb Foundation Trust	East Sussex County Council	Sussex Partnership Foundation NHS Trust
Surrey and Sussex Healthcare NHS Trust	Western Sussex Hospitals NHS Foundation Trust	Brighton & Sussex University Hospitals NHS Trust	SECAmb Foundation Trust
Surrey County Council	GP providers	Sussex Community NHS Foundation Trust	GP providers
West Sussex County Council	IC24	Sussex Partnership Foundation NHS Trust	IC24
Sussex Community NHS Foundation Trust		SECAmb Foundation Trust	
Sussex Partnership Foundation NHS Trust		GP providers	
SECAmb Foundation Trust		IC24	
Surrey and Borders Partnership Foundation Trust			
GP providers			
IC24			

Introduction

Our Sustainability and Transformation footprint is comprised of 23 partner organisations from across all health sectors, including social care, and serves a population of around 2 million people.

The footprint combines large areas of relative affluence with pockets of severe deprivation, leading to very different health challenges, and substantial health inequalities.

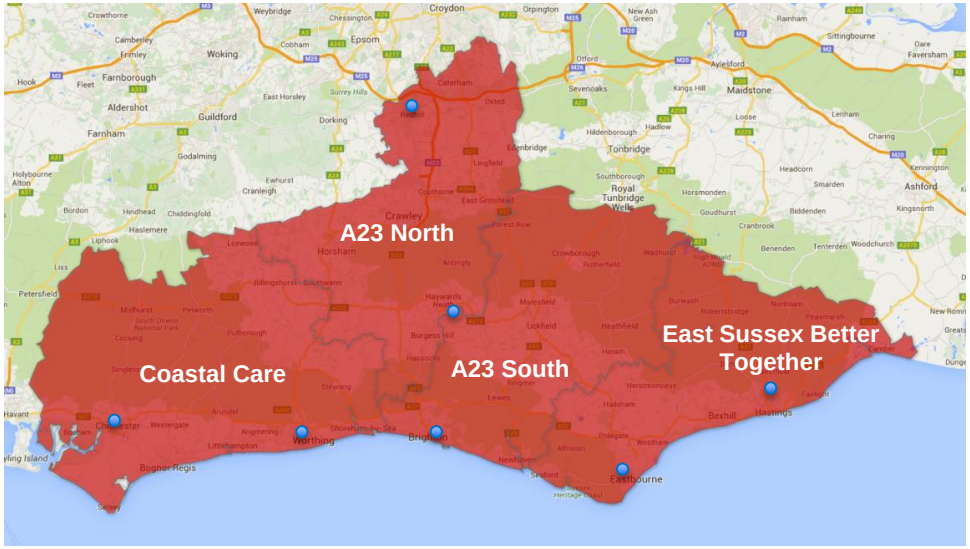
There is a larger than average elderly and ageing population, which when combined with the rurality and variable transport links makes supporting this complex and vulnerable cohort a significant challenge. In contrast, in urban areas, lifestyle factors and mental health prevalence, and a high proportion of looked after children and children in poverty, offer equal challenges of a very different nature.

The provider landscape is also complex, with variable performance across all sectors, and across the 7 acute sites.

The necessary planning to address this will occur at three levels:

- In local communities or individual organisations
- In wider areas (e.g., Coastal Care and ESBT)
- STP wide

The solutions within the STP will focus on population need, overall care and quality, and system-wide affordability.



Section 1: Leadership, governance & engagement

The Sussex and East Surrey STP development process is Chaired by Michael Wilson, with Wendy Carberry as the Senior Responsible Officer.

A Programme Board has formed, constituted of the Chief Officers/ Chief Executives of all partner organisations and includes GP representatives, and is meeting fortnightly to drive progress in the development of the STP. The Programme Board has established Terms of Reference that define how the group will work together to make the decisions required to deliver sustainability to the region. The Urgent and Emergency Care Network (UECN) shares it's footprint with the STP and the chair of the UECN is a member of the STP Programme Board. This will facilitate coordination and planning and provides opportunity to drive improvements in Urgent and Emergency Care at pace.

We will build on established programmes of work within the footprint, such as East Sussex Better Together, building on the detailed analysis and extensive local patient and clinical engagement that these programmes have developed. At the same time, we recognise that additional solutions will be required on an STP-wide basis.

It has been agreed that the Programme Board will sign-off the STP to enable the pace and scale of change required. Decisions at Programme Board will be reached by discussion and consensus.

Representatives from the 4 County Councils are members of the Programme Board, and – building on local programmes where relevant relationships already exist - communications channels with County Council Chief Executives and Health and Wellbeing Boards are currently being established for STP-level initiatives.

To support progress in this initial phase of framing the problems, sub-groups have been formed and tasked with defining the performance gaps: Health and Wellbeing is led by the local Public Health leads, Care and Quality by partner quality leads and Finance and Efficiency by partner Directors of Finance.

As we move into the next phase of development of the STP, we have invited Healthwatch to attend our Programme Board such that the views of the public and patients are well represented at this level. Once emerging solutions are developing we will engage more broadly with patients and the public to seek input on solutions and further areas of focus.

We have found substantial local appetite for change, with clinicians very engaged across the different levels of planning that exist within the STP:

- We will build on the clinical engagement processes that are working within the local programmes within the STP footprint
- Our Programme Board membership includes GPs and we are engaging with the Sussex Clinical Senate
- We will involve the leadership of the AHSN and of Brighton & Sussex Medical School in development of solutions
- As we identify priority clinical pathways for redesign we will engage relevant clinicians to develop solutions

We note the importance of communications to deliverability of the STP, and will ensure that good communications are threaded through the STP.

Section 2a: Improving the health of people in your area (1 of 2)

The STP footprint has a growing and ageing population, with an increasing prevalence of long term conditions (LTCs) and in particular a significant older population living with multiple LTCs.

We have a detailed understanding of the strengths and challenges facing our communities, developed through extensive community asset mapping and JSNA processes, and opportunity analysis using Right Care data. Health inequalities exist within every locality but present additional challenges for specific areas across the footprint, particularly in coastal towns, where pockets of deprivation lead to significantly poorer health outcomes and fewer disability free years of life lived. As a result there are thousands of people living in poor health with increasing health and social care costs and thousands of unnecessary deaths every year which could be avoided. The health and wellbeing gap across the footprint is exacerbated by social isolation across different segments of society.

Mental and physical health are intrinsically linked, with illness in one increasing the risk of the other. Local research has determined that 80% of the additional risk of mortality associated with mental health conditions is linked to physical illness such as cardiovascular disease and cancer. Similarly we know people in our communities with long-term conditions are also two to three times more likely to experience mental health problems, and at least 30 per cent of people with a long-term condition also have a mental health problem.

We recognise the impact diabetes and obesity have locally, representing significant drivers of cardiovascular disease expenditure and death, and primary and secondary prevention is a key part of our new model of care. Given the size and growth of our elderly population, developing an enhanced dementia model of care is crucial. We recognise the current limitations of Children's services, and the pressures they will face in the future, making them a priority for our STP.

Health and wellbeing issues across the footprint have been prioritised based on deaths, years of life lost, healthcare costs and health inequalities. This approach leads us to focus on the following issues to deliver the greatest health and wellbeing improvement:

Issues	Annual deaths	CCG Programme Budget Costs (13-14)	Annual excess deaths in most deprived quintile
Cardiovascular	6,191	£332m	282
Cancer	5,437	£252m	250
Respiratory	2,718	£280m	228
Mental Health	1,663	£500m	136

Section 2a: Improving the health of people in your area (2 of 2)

Promoting prevention is central to the STP and must happen across the system to prevent long term conditions and achieve a significant return on any investment:

- Preventing health problems developing in the first place by promoting healthy lifestyles, addressing social isolation and supporting changes in behaviours relating to smoking, diet, exercise and alcohol. Social prescribing represents one of the emerging areas of best practice from the region (primary prevention)
- Stopping health problems from getting worse through early detection and effective management in primary care (secondary prevention)
- Reducing the impact of disease on people's health and wellbeing such as by delaying or eliminating the onset of complications, implementing rehabilitation and re-ablement to restore patients' independence, and promoting self-care, to reduce the impact of disease on their quality of life (tertiary prevention)

Issue identification and planning at an STP level provides a new opportunity for partners across the footprint to further develop and implement innovative prevention models on a larger scale, benefitting from a larger catchment and pooling of resources. This broad planning and coordination will be informed by local community engagement to co-develop initiatives. In order to focus on place-based needs and ensure that the interventions put in place are locally relevant – interventions will take place through local health plans and delivery will be aligned with local Health and Wellbeing Strategies.

In addition, as an STP partnership our health, social care and third sector workforce represents a large population with greater opportunities for engagement. We will develop a health improvement plan for our combined workforce that makes best use of national programmes such as PHE's 'One You' and the 'Workforce Wellbeing Charter'. Workforce approaches also provide a testing ground for innovative new interventions before scaling up across the STP footprint.

We understand in detail the challenges that face our communities and wider health system and have developed a number of innovative solutions in areas to address local challenges, but acknowledge that impact is not yet at the pace and scale we would like.

Section 2b: Improving care and quality of services 1 of 2

To improve care and quality across the footprint a number of priorities have been put forward, some of which serve the needs of multiple provider types and others that are issues that manifest themselves in acute failure, requiring effective working across the whole STP footprint.

Driven by an ageing population there is an increase in both the acuity and dependency of service users, with a well documented increase in co-morbidities. This places demand for increased skills and capabilities, capacity and responsiveness on the system of care.

Referral to Treatment, cancer waits and A&E 4 hour performance have shown a prolonged decline and planning for long term solutions to these issues is a priority for the STP footprint. While all four Acute Trusts have challenges in these areas, they are currently particularly stark at BSUH and ESHT (the latter in special measures) where trust performance and CQC inspections are below the accepted standard. The consequences of trying to address these challenges have included very high levels bank and agency use, as highlighted by CQC and underlined by direct negative impact on financial performance.

Six clear care and quality priorities have been developed through review of key quality indicators, Right Care data analysis and discussion with partner organisation's quality leads -

1. **Cancer outcomes** –Cancer diagnosis rates are low across the footprint as are outcomes, in particular 1 year survival. Additionally, screening programmes are not achieving sufficient reach and access to diagnostics and treatments is becoming an increasing priority
2. **Stroke outcomes** – There are key gaps in stroke provision and quality of provision across the footprint. Priorities include delivery of consistent 7 day access, rehabilitation and social support following medical discharge ("Life after Stroke"). A whole pathway approach is needed to ensure comprehensive support is consistently available
3. **Mental health access and outcomes** – There is a high prevalence of mental ill health and suicidality in the footprint and a need to improve access to services for the most vulnerable e.g. BME communities and PLD. A lack of an integrated perinatal pathway, across acute and community, along with inconsistent access to CAMHS (partly due to a lack of availability) and well co-ordinated early intervention services, reduces opportunities for early detection and prevention.
4. **Management of long term conditions** – broadly speaking, existing methods of managing long term conditions are outdated. People living with diseases such as diabetes and heart failure are not adequately empowered and supported to prevent the deterioration of their condition, resulting in compromised population health outcomes and high costs of care. Innovative practices are emerging but these are not yet consistently delivered at the scale needed to close the sustainability gap
5. **Support to the frail and elderly** – traditional silo-ed clinical, organisational and funding structures fail to address the broad ranging and interlinked clinical and psycho-social aspects of managing care for frail elderly people. New models are needed that proactively address frailty itself, accommodate dementia and co-morbidities and provide enhanced, consistent and responsive access to End of Life Care, implementing GSF Prognostic Indicator best practice
6. **Maternity and children's services** – noting that the footprint includes large numbers of complex families, looked-after children and children in poverty

Section 2b: Improving care and quality of services 2 of 2

To address problems in care and quality, it is essential that we address **fragmented care pathways across care settings** – these discontinuities in care allow people's health to deteriorate unnecessarily, and affect vulnerable parts of our communities the most, reinforcing health inequalities across ages and social strata. They also prevent flow across the system, such that expensive capacity is currently used ineffectively. Addressing these requires exploration of fundamentally **new models of care**, with a focus on sufficient local design and engagement that the models work robustly:

- There is a need to build **resilient care systems** that address significant gaps in both service provision and capacity, and drive effective integration across care settings, including addressing the following issues:
  - **Growing volume of demand and complexity of patients**
  - **Need to maintain flow of patients through the system**
  - **Need for greater resilience in the community (Primary, community, social care, mental health, etc):** including a fundamental evolution of the model of care if it is to mitigate acute activity growth and ensure we have primary care models which are fit for purpose, to invest in and strengthen.
  - **Need for better integration of services:** healthcare with healthcare across sectors (i.e., mental health and physical health; primary, community, and secondary); healthcare with social care – such that services are responsive to the needs of key groups of patients.
  - **Need to address market failures amongst providers of social care** that lead to under-availability of domiciliary care workforce in particular geographies, and that also affect the care home market. Care and quality within care homes and domiciliary care has a significant impact on both patients and other providers in the footprint, compromising quality of care, total health system costs and the experience of service users. Carers and the 3rd sector represent an underserved and untapped resource that we will effectively engage in developing high quality, sustainable care models.
  - **Lack of sufficient networking of acute services** across the footprint to enable a sustainable design of acute services, including a sustainable acute workforce in key disciplines.
  - **Need for commissioning reform:** this includes reducing transaction costs, and to seek greater consistency in models of care where this is appropriate to improving quality.
- **Current IT systems do not meet the needs of patients, or of organisations within the system:** we need to address integrated care records and the development of interoperable IT systems through our Digital Roadmap, the footprint of which matches that of our STP.
- **Workforce** – Establishment and vacancy issues are widespread, and the workforce is ageing. New staffing models, enhanced education and training programmes and greater collaboration across the footprint is needed to deliver the right skills in the right place at the right time.

Section 2c: Improving productivity and closing the local financial gap

Our emerging projections show that on a 'do nothing' basis, the footprint will have a financial gap of approximately £580m (~14% of all recurrent allocations[1]) by 2020-21[2]. This is likely to be an under-estimate of the true gap, due to: 1. Highly preliminary social care projections that do not yet show a growing gap over time; 2. No gap modelled for public health. The financial deficit has already grown from break even in 2014-15 to £123m in 2015-16. This widening gap means that the STP needs to act urgently. The longer we leave before taking action, the bigger the challenge gets. The table below shows the net surplus/deficit by sector in 15/16 and 20/21.

Sussex & East Surrey (£m)	Overall estimated STP income[1]	CCG Surplus (deficit)	NHS Provider Surplus (deficit)	Adult Social Care Surplus (deficit)	Primary Care Surplus (deficit)	Specialised Commissioning Surplus (deficit)	Total STP Surplus (deficit)	As a proportion of STP Income
2015/16	£ 3,938	£ 17	-£ 110	-£ 30	n/a	n/a	**-£ 123**	-3%
2020/21	£ 4,281	-£ 118	-£ 365	-£ 30	-£ 33	-£ 34	**-£ 580**	-14%

The key drivers to this challenge are:

- Some CCGs are underfunded, relative to population: Coastal West Sussex, Crawley and East Surrey; while others are over-funded: Brighton & Hove and Hastings & Rother. This inequality consequently drives local financial challenges. As a result, half of the CCGs have QIPP challenges of greater than £10m in 2016-17.
- Two providers account for more than half of the provider deficit in 2015-16 in the area: Brighton & Sussex University Hospitals NHS Trust and East Sussex Healthcare NHS Trust. There is a requirement to spend on upgrading the estate in general and in particular at BSUH in relation to the signed-off business case.
- The cost of securing a workforce with the right skills, and agency staffing cause cost pressures.
- The area faces an ageing population, many with multiple long-term conditions, and spending on acute services in secondary providers is increasing above growth in allocations. Specialised services are also experiencing financial challenges.
- The demand on primary care and community physical and mental health is also out-stripping funding, which is causing additional financial stress. As a result, GP lists are closing around the area, further compounding the problem.
- Against a back-drop of adult social care spending reductions over the last 5 years and council funding decreases over the coming five years, the burden has fallen on health services to cope with increasing levels of activity and acuity.
- East Surrey CCG are under legal directions to manage their financial challenge.

The major areas of focus to return the area to aggregate balance are therefore:

- How will the area balance demand, making best use of the capacity and skills from each different type of provider, such as community care undertaking some current acute activity?
- How can services be redesigned to increase levels of efficiency, such as consolidating activity into fewer, more specialist providers? This has the potential to reduce the current level of access.
- How will the area design different care models, to attract, recruit and retain staff for a re-shaped workforce, and cope with an increasing population of older people living with multiple co-morbidities?
- How can technology drive operational efficiencies and reduce demand?
- How will we use our estates to deliver an affordable model of care across the STP area?

Notes on methodology:

[1] Includes Estimated CCG, Primary Care, Specialised Commissioning and Social Care allocations

[2] Includes: CCGs, Acute, MH, Community, Primary Care, Adult Social Care, Specialised Commissioning, Ambulance Service. 'Do nothing' assumes 2.5% growth, 0% CIPs and efficiencies

Section 3: Your emerging priorities

We are developing a programme of work that will see issues addressed at different levels within our partnership:

- **At STP level** – for issues where additional scale, networking and pooling of resources is needed to achieve greatest impact
- **In local place-based planning groups –** building on existing programmes, for example enabling effective service integration
- **In local communities and individual organisations -** where the effects of an issue and control over it reside at that level

Our emerging priorities can be grouped into eight initiative areas, as detailed in the table below:

Emerging priority	Rationale/ comments
1. New models of care for population-based catchments, to enable development and delivery of integrated care systems	This includes supporting, investing in and improving general practice. It includes health-to-health integration across sectors, and health-to-social care integration. This priority also provides the key lever for many of our identified clinical outcome-based gaps
2. New models of care for acute service delivery and networking	This is the solution to the significant and longstanding access issues relating to elective, non-elective and diagnostic services; working with the UECN to improve non-elective access is an early priority for our STP. To continue to offer the secondary and tertiary services provided we'll have to work together in an integrated way.
3. Initiatives relating to public health, prevention and self-care	To address the identified health and well-being gaps, prevent ill-health and moderate demand for healthcare
4. Workforce development, both to enable new roles within integrated services, and to address sector-specific shortages	This is required to enable development of integrated multi-disciplinary teams, and to address agency usage and capacity gaps
5. Provider productivity improvements	To address opportunities highlighted through e.g. Carter and Reference Costs, and to provide a substantial contribution towards achieving financial balance
6. Engagement with patients, the public, carers and workforce	To enable design of initiatives around patients, and to ensure designs can be implemented
7. Affordable, fit-for-purpose estates	This will need to include ensuring that the Brighton redevelopment is implemented in a way that is affordable, and also addressing estates for community multidisciplinary teams
8. IT that meets requirements for electronic care record and interoperability	To address identified gaps in patient service, and provider efficiency, that result from current silo-ed IT systems, driving progress against our Digital Roadmap.

Section 4: Support you would like

As we work to redirect resources between care settings to improve quality of care and efficiency a degree of double-running costs are inevitable. We will work to minimise these, but will require central pump-priming funding to manage the launch or expansion of new services before demand for existing services abates. As we put solutions together, we will be asking for early national discussions on how to enable changes to happen.

We will need support from national bodies on changes to organisational arrangements where these affect statutory bodies that could present barriers to change, and envisage that many other footprints will be faced with this same challenge.

We ask that timelines asked of our footprint realistically reflect the scale of our ambition, and that process management is lean such that we can remain focused on delivery.

We also request support in the removal of barriers of new workforce models which are fundamental pillars of our regions' future sustainability. We request permission to explore new models and would welcome the opportunity to play a part in the development and testing of such initiatives, including:

- A new hybrid primary care contracting model and in-house education, enabling new models of care
- Training to develop band 4 nurses in order to fill the significant band 5 workforce gap

We require support to streamline data sharing agreement arrangements to enable information and technology enabled transformations.

As we commit the time of leadership to the development of our STP, we request that assurance processes are reviewed and where possible simplified to enable a focus on solving acknowledged issues in the long term, and reflect establishing place-based structures.

We welcome an open dialogue about the nature and timing of our proposed changes as they develop such that we can minimise the chance of plans being politically undeliverable.

We will also need to develop proposals on implementation support that will be needed after our STP is submitted to ensure we continue to move at pace as we start to make changes on the ground.