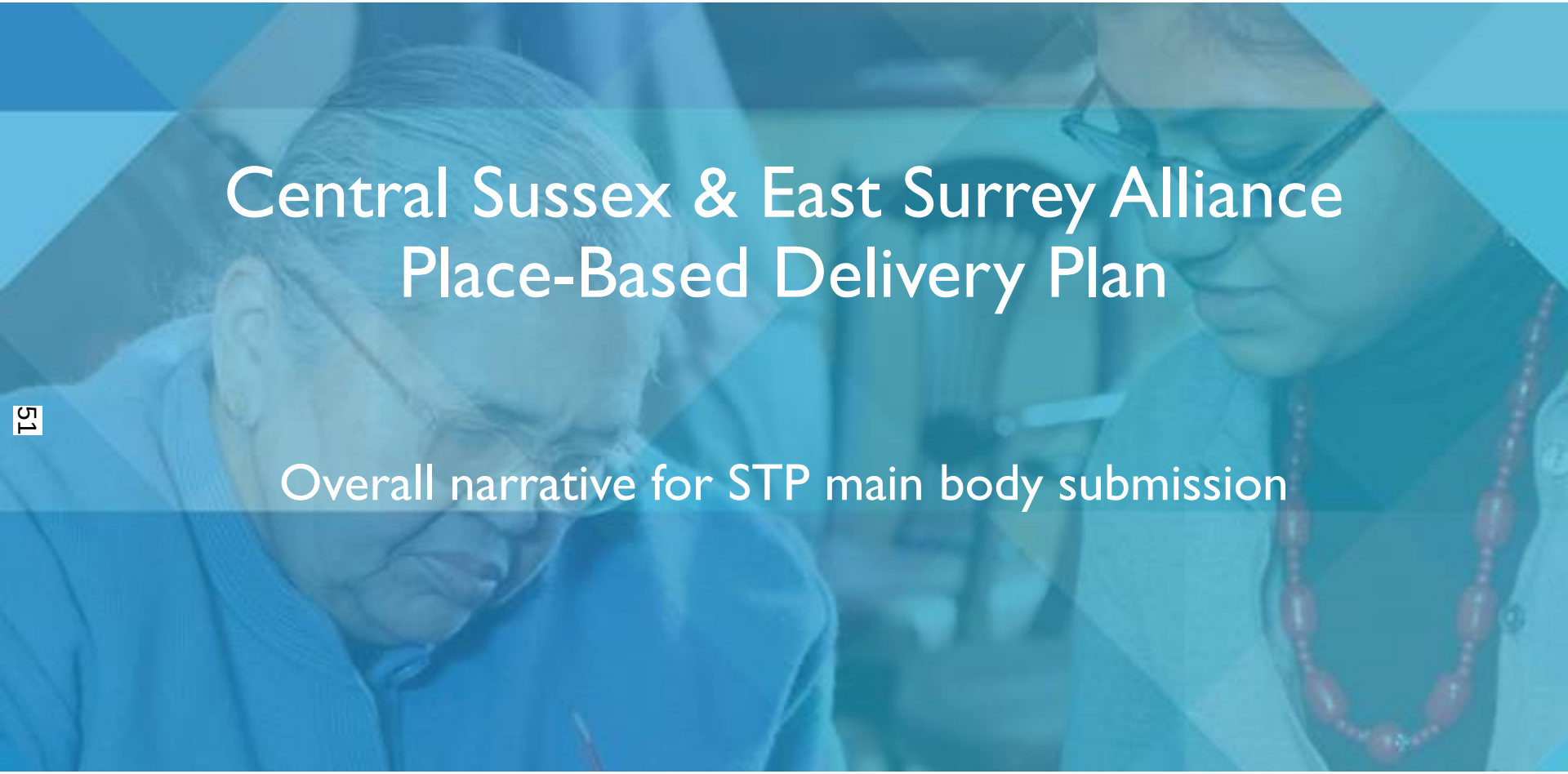


Central Sussex & East Surrey Alliance Place-Based Delivery Plan

Overall narrative for STP main body submission

Central Sussex & East Surrey Alliance

Contents

Central Sussex & East Surrey Alliance

Executive summary

Case for change

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

Vision & priorities

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

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

MCP is the right model

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

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

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

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

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

Delivery structure

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

What it will take to execute

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

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

Clinical leadership	Workforce	Change Management	Programme delivery
Technology	Estates	Investment	Contracting

Finances

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

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

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

See slide 17

Timeline

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

Vanguard ready

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

We have:

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

Case for change: the challenges that we face

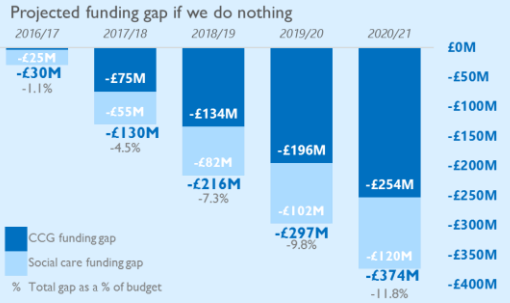
The national and local health and funding issues that must be addressed

Primary care has been underfunded for a long time

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

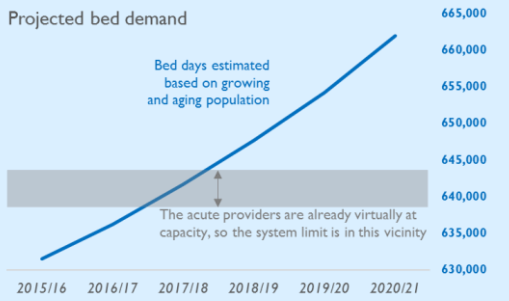
Continuing to operate as we currently are is not an option

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



Note: data shows position as estimated in July

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



The population is growing, and growing older

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

The overall health of children and working age adults is deteriorating

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

Cancer and stroke need a particular focus

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

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

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

Care quality issues need to be addressed

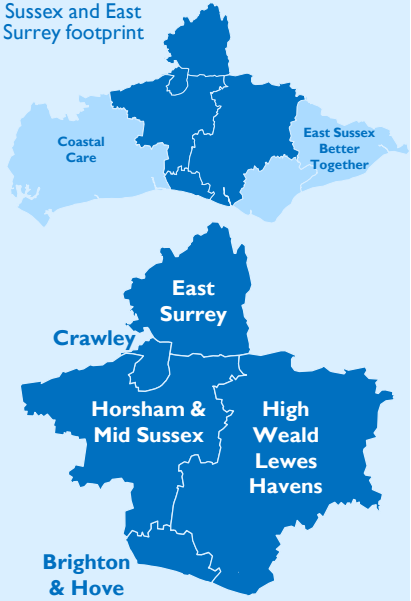
- Cancer and direct diagnostics are insufficient to meet NICE guidelines NG12
- Several other major areas of care have been identified as requiring improvement:
  - mental health detection, access and outcomes
  - LTCM prevention and support
  - support to frail and complex patients
  - maternity and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

Social factors are having a direct impact on health

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

Case for change: understanding the CSESA place today

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



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

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

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

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

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

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

Our vision for CSESA

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

Our strategic objectives

Care designed for the needs of local populations

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

Meaningful integration of providers

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

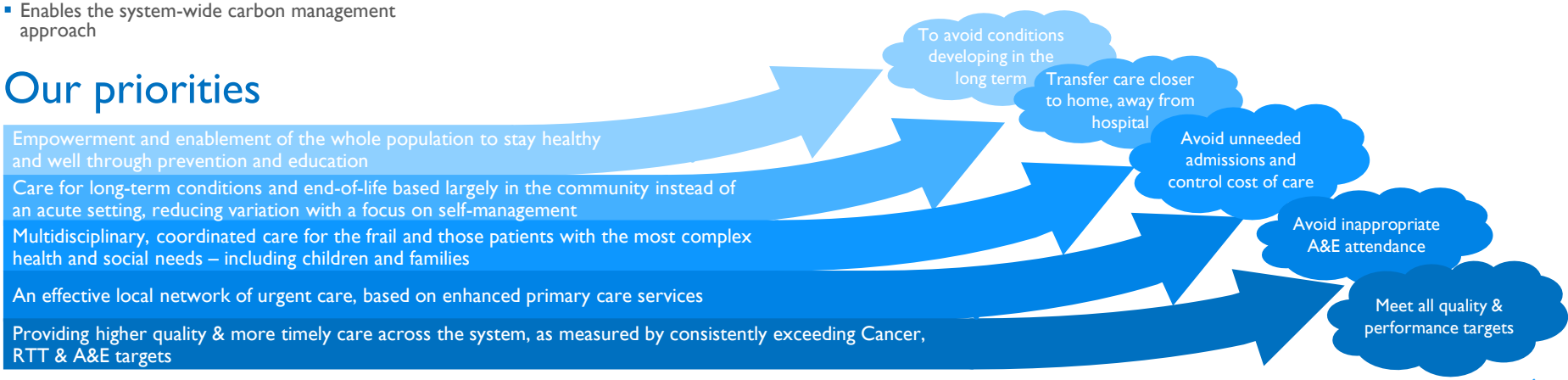
Sustainability of primary care

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

Sustainability of acute care

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

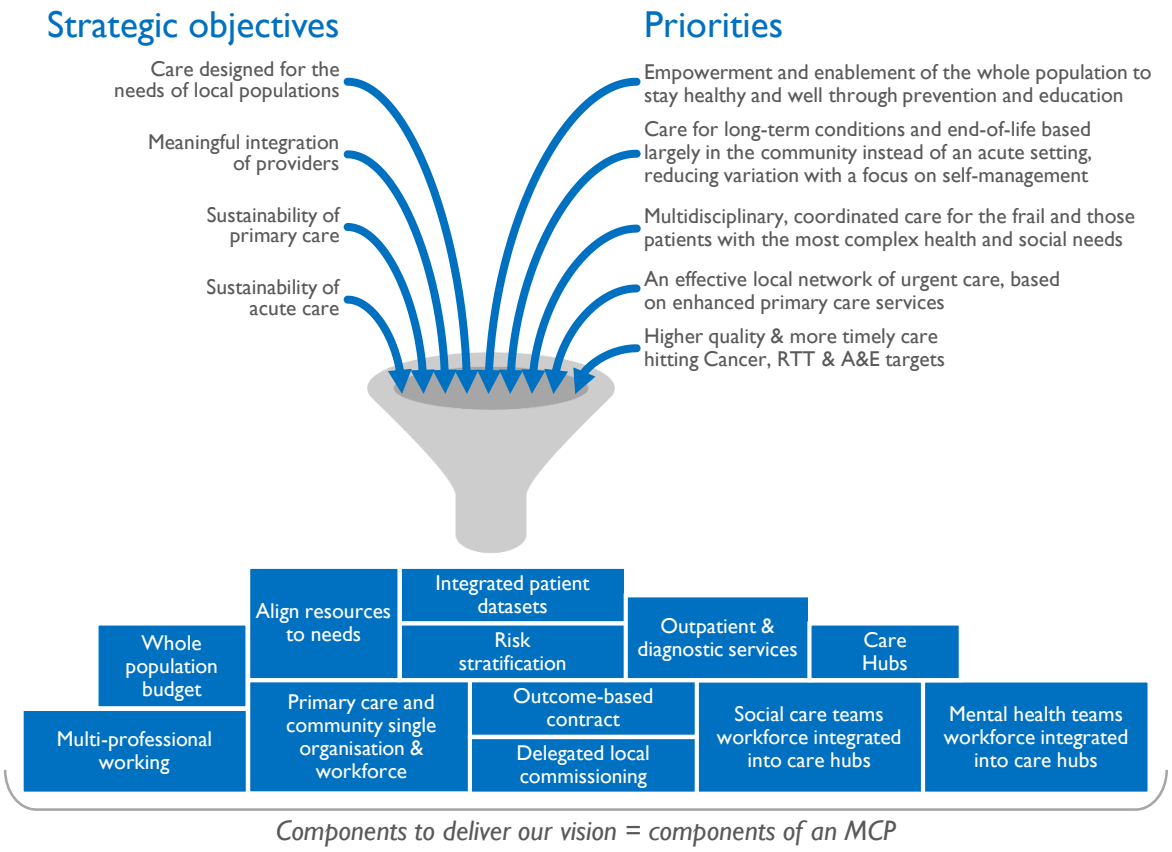
Our priorities



Why an MCP is the right model for accountable care

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

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



Components to deliver our vision = components of an MCP

2 We are already building strong foundations for the MCP model

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

3 We have strong leadership from our primary care clinicians

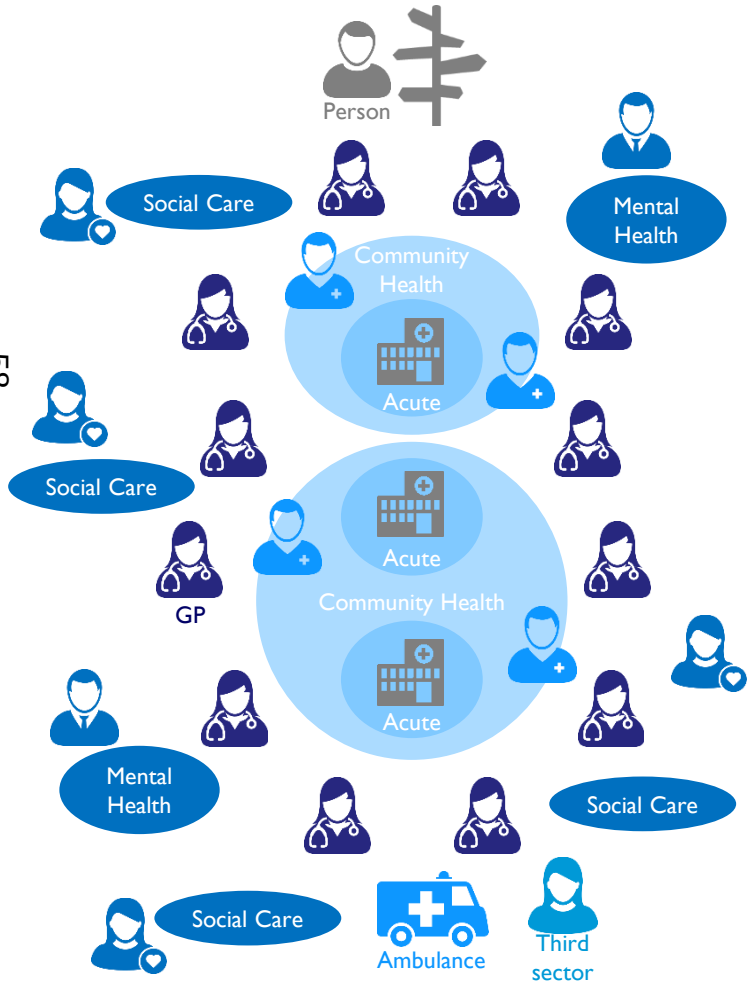
- There is very strong support from GPs across the CSESA place.
- GPs are the driving force behind change and will be providing the clinical leadership to drive the pulling of activity from the acute setting.
- Two-thirds of the workload on the system is as a result of LTCs which by their nature should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

What will be different in an MCP

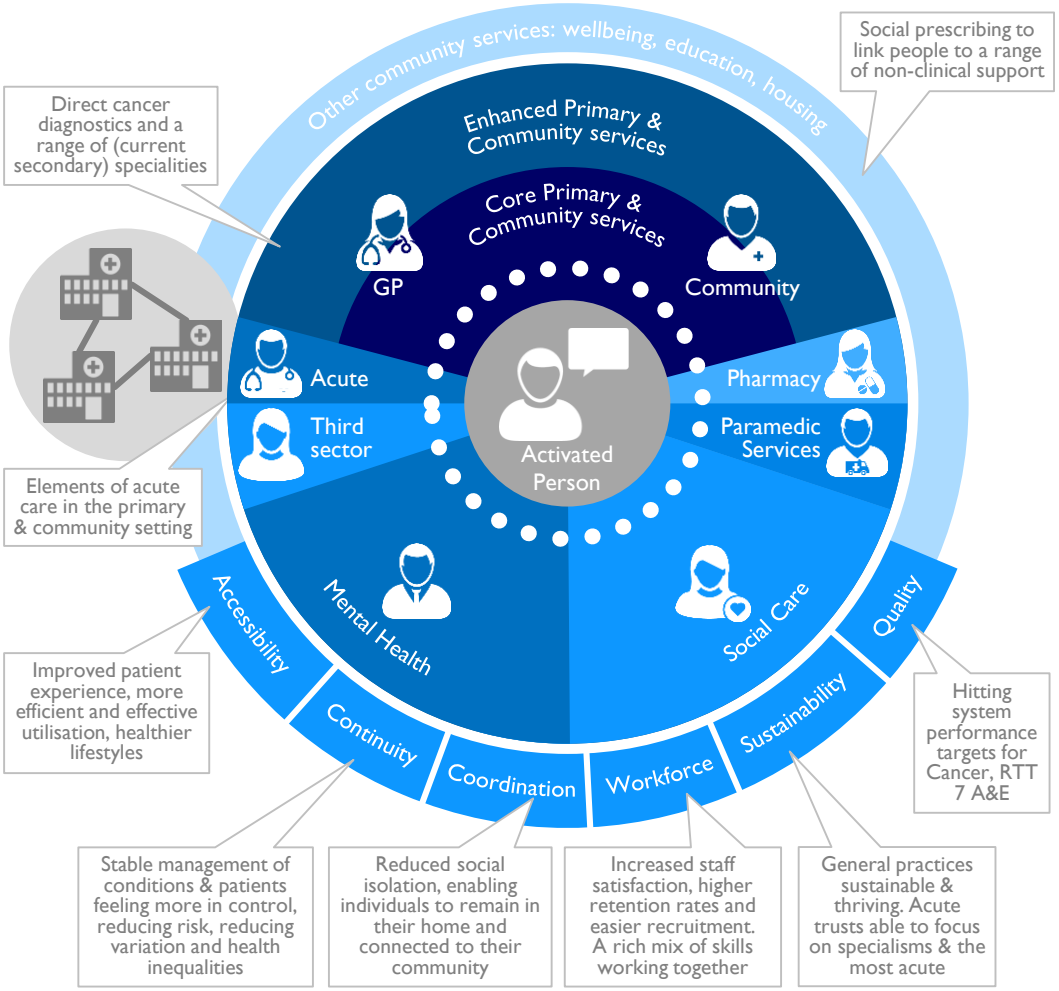
The MCP model arranges care around the person and integrates out-of-hospital services

This is today

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



This is our future



What the MCP will look like

The key differences in how an MCP will work

Organisational consolidation

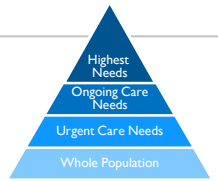
- Integrated primary and community care via networks of general practices. This may mean federations or super practices joining organisations with community providers – or it may mean a prime/subcontractor model
- Organised into 20 care hubs of 30-50k, with a minimum total population of 100k
- Mix of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

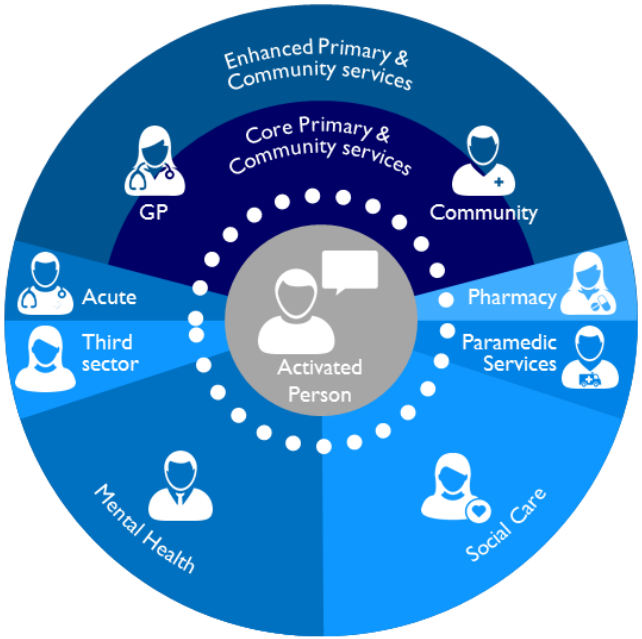
MCP Integrator

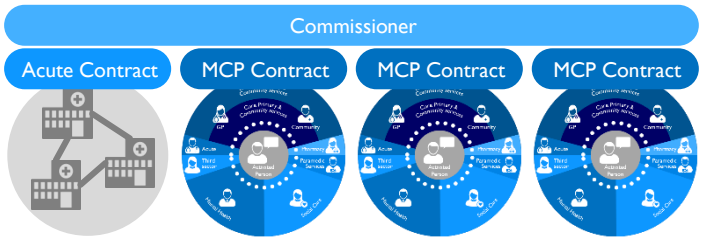
- The model will include a provider-based function to oversee all in-MCP services and respond to commissioner, effectively running delegated commissioning and taking make-or-buy decisions
- Uses dynamic analytics so that continuous data is available info to clinicians, organisations, system and used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

Data driven care model

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







3 MCPs shown not indicative of anticipated number

Patient at the centre

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

Balanced workforce

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

Devolved finance & contracting

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

We have strong foundations from which to grow our MCP

We will focus on building the care hub locality services first

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

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

Sep 2017

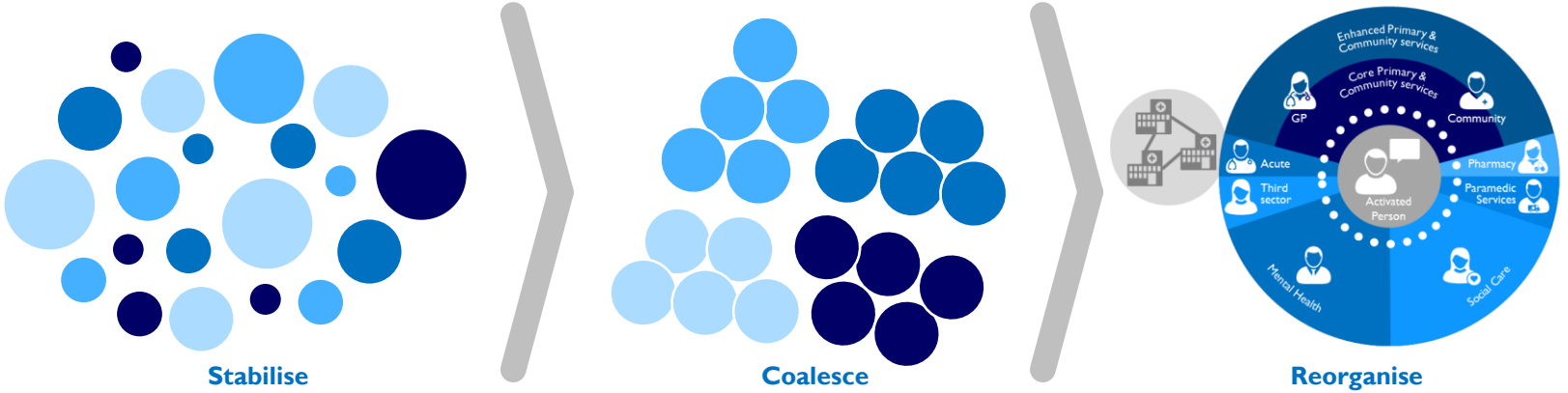
Hold Public Consultation
Gather patient and public feedback on the rationale for, approach to, construction of and number of MCPs

March 2018
Dates TBC subject to purdah

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

Sep 2018

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



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

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

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

How our organisational capability will mature

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

The WISH maturity model sets out 5 capability 'ladders'

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

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

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

Where we want to be

Where we are now

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

WISH
مؤتمر القمة العالمي للابتكار في الرعاية الصحية
World Innovation Summit for Health

The clinical approach within the MCP model

We have 4 clinical priorities

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

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

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

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

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

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

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

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

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

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

Timescales

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

What it will take to execute

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

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

Investment

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

Contracting

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

Leadership Development

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

Workforce

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

Technology

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

Estates

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

Change Management

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

Programme delivery

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

Assumptions driving our financial model

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

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

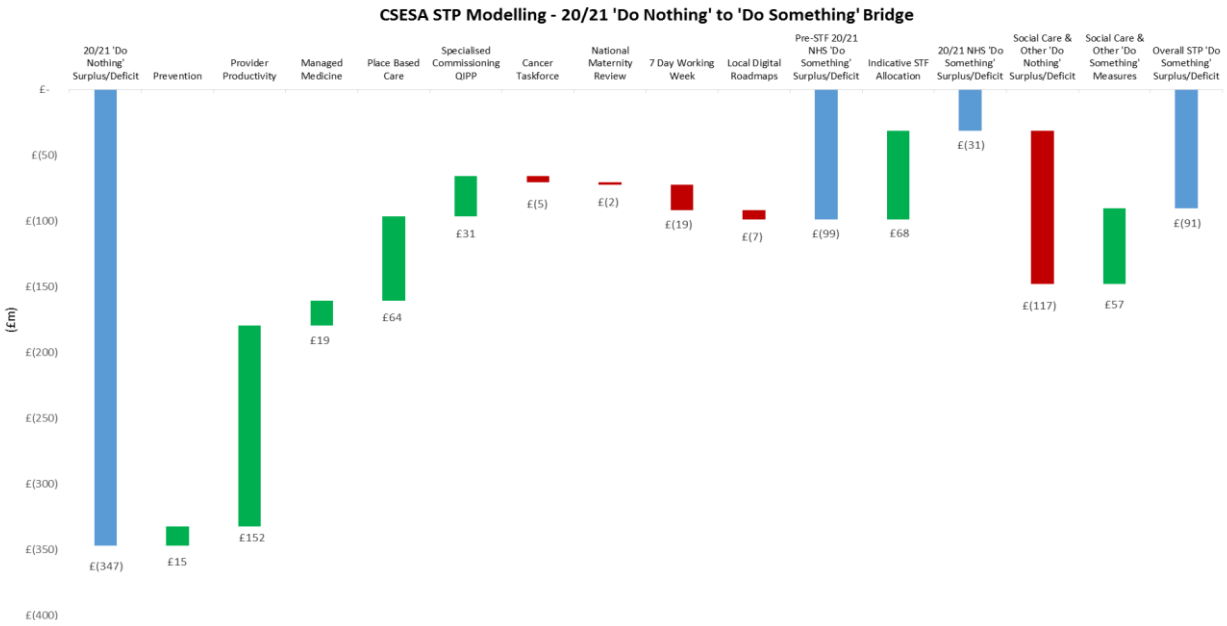
The model then de-duplicates savings by applying business logic to historical per-person data. It also assumes a benefits lag. After these adjustments the expected annual saving is:

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

← Indicative estimate that that there are sufficient savings available

Finance projection

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



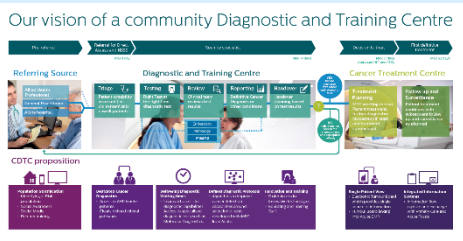
By Year 5 we will have reduced the healthcare deficit to £31m

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

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

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

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



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

Governance

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

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

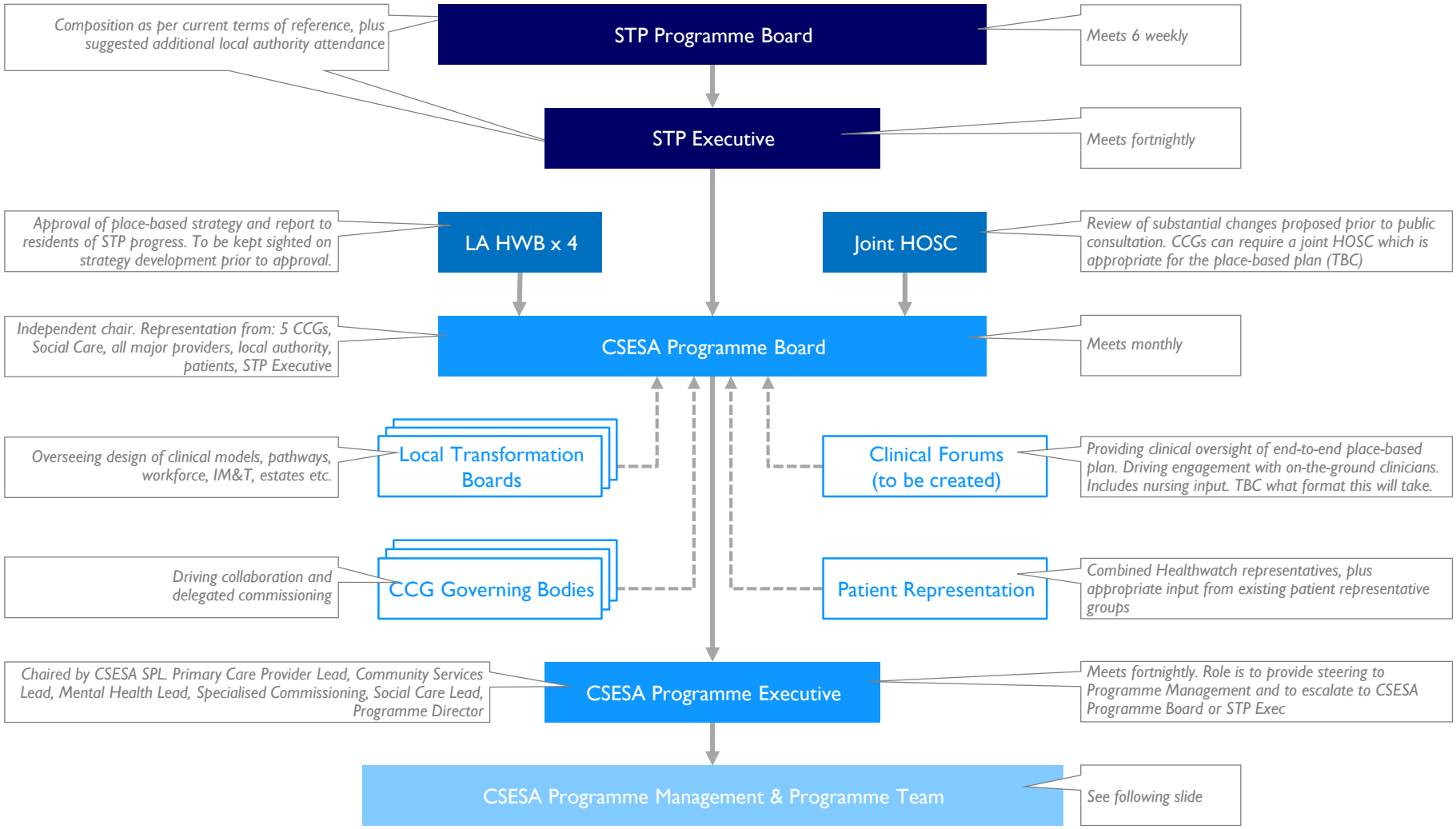
- Note that A common case for change, a common set of principles, a common MCP approach and common governance will not necessarily result in a singular outcome in terms of organisational form or local delivery model

Principles of Governance

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

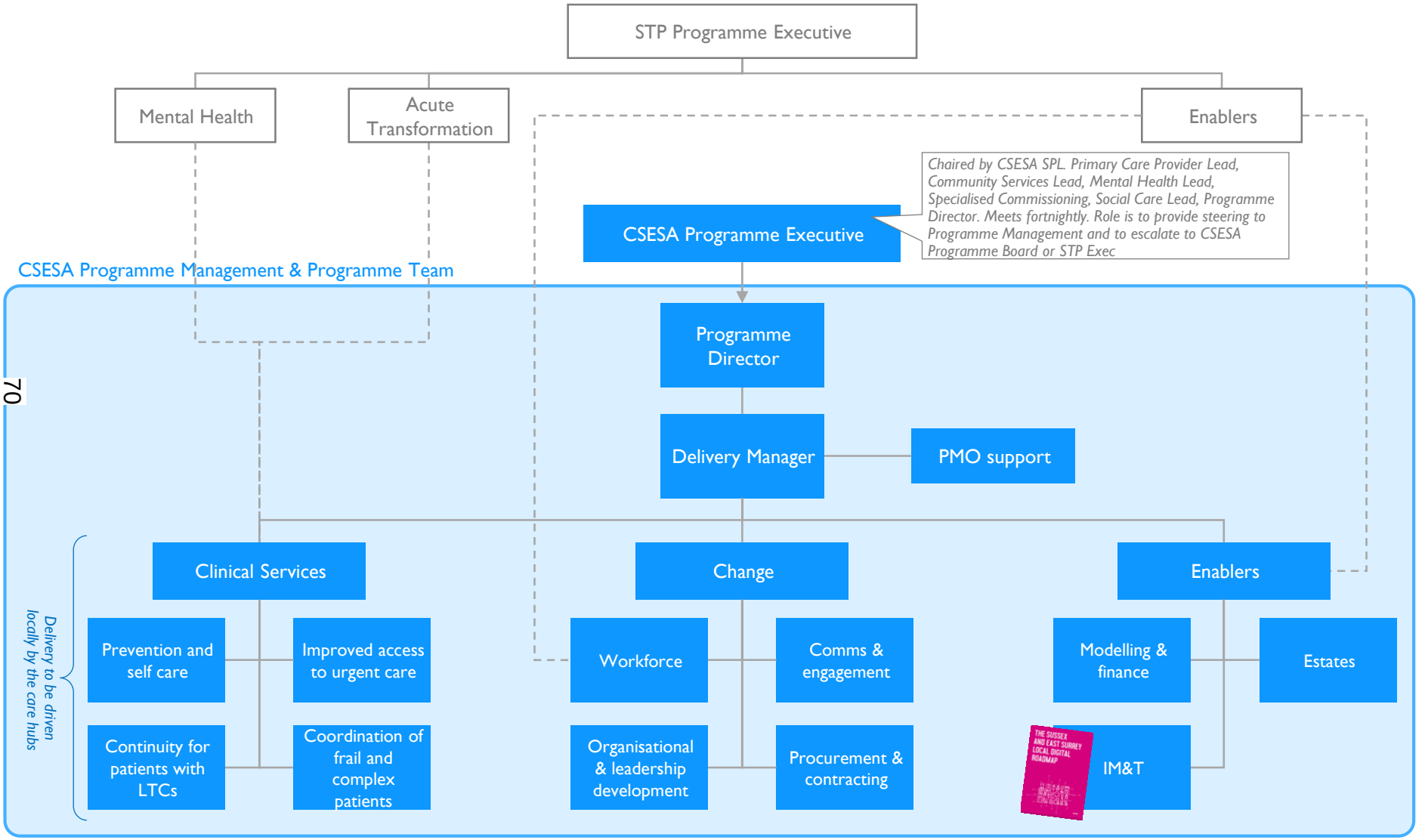
Programme and transition governance model

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



Delivery programme structure

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



In conclusion

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

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

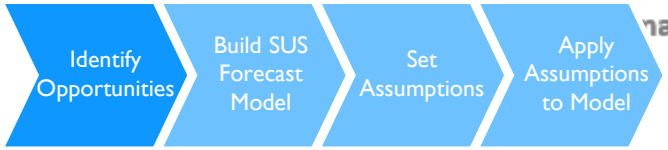
Appendix A

Financial Modelling

Modelling Approach

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

We have identified 9 opportunity areas



Lever	Definition
Frailty	Any non elective admission for a patient over 75, with LOS <7 days
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Step Down Care	Excess bed days consumed by patients over 75

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

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

We have built a sophisticated model

Identify Opportunities → Build SUS Forecast Model → Set Assumptions → Apply Assumptions to Model

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

Demographic Growth and Demographic Change

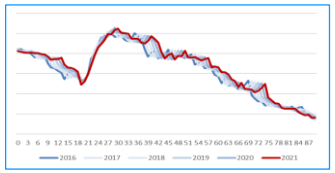
- Using granular ONS population data, we have extrapolated out episode-level FY2015/16 SUS data out to FY2020/21. This equates to 4,000,000 rows of data in the model, and is built on MS SQL-Server.
  - For example, if a CCG has an aging population, then the demand for services that the elderly will consume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

Non Demographic Growth

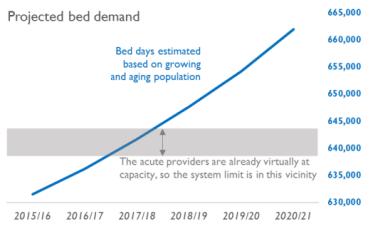
- Patient's expectations are increasing, as are advances in medical treatment. This has lead to longer term trends in activity that are, in many cases, over and above the demographic change.
- We have applied 3-year growth trends at POD / CCG level to the data.

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

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



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



We set the levels for our assumptions

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

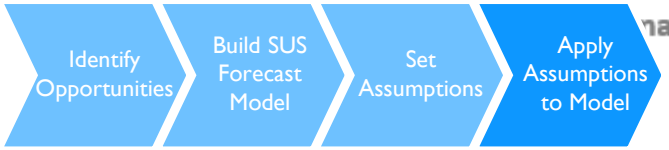
Lever	Definition	Reduction assumption (worst case)	Max. saving	% saving	Cost of alternative…	…based on
Frailty	Any non elective admission for a patient over 75, with LOS <7 days	The SASH frailty business case assumes a Frailty Centre to provide a multidisciplinary approach to reducing frailty admissions;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

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

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

← Indicative estimate that that there are sufficient savings available

The model enables users to test the impact of different assumptions



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

A quick overview of the Excel model

1 Do Nothing view, aligned with 2020Delivery financial model

2 Opportunities, and extent to which activity could be reduced

Do Nothing

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

	Levers	**Spend (2016)**			**2017**	**2018**	**2019**	**2020**
2	Frailty	£ 19.3m	40%	*Patient is over 75, LOS < 7, NEL*	10%	20%	30%	40%
3	Elective Reduction	£ 296.3m	10%	*PCD is EL, DC or Out Patient*	3%	5%	8%	10%
4	Step Down Care	£ 8.1m	50%	*Age > = 75, Excess Bed Days*	13%	25%	38%	50%
5	Non Elective Admission	£ 19.7m	30%	*NEL, LOS <= 1*	8%	15%	23%	30%
6	A&E	£ 26.2m	30%	*HRG in VB07Z, VB08Z, VB09Z, VB11Z; no*	8%	15%	23%	30%
7	First Outpatient Appointments	£ 47.4m	5%	*First OP*	1%	3%	4%	5%
8	Long Term Conditions	£ 2.9m	50%	*HRG in Diabetes, Pulmonary, Arthritis or A*	13%	25%	38%	50%
9	Complex Patients	£ 35.6m	30%	*Previous CCG analysis (see tab)*	8%	15%	23%	30%
10	PBR Excluded Drugs (CCG)	£ 19.2m	20%		5%	10%	15%	20%
11	PBR Excluded Drugs (SpecComm)	£ 37.0m	20%		5%	10%	15%	20%

3 Ramp-up profile of opportunities

Do Something - based on Levers

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

4 View of Acute spend once opportunities have been implemented

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

5 Cost of reducing / re-provisioning each opportunity

Prevention / Reprovisioning Costs

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

	Levers		**Unit Cost**	**Units**	
	Frailty		£ 884	*per admission reduced*	*Based on SASH bus case*
	Elective Reduction	EL	£ 981	*per elective reduced*	*Avg cost of Day Case*
	"	DC	£ 450	*per day case reduced*	*Avg cost of OP1 + 2xOP2*
	"	OP	£ 40	*per out patient appointment saved*	*Estimate*
	Step Down Care		£ 150	*per excess bed day saved*	*Estimate*
	Non Elective Admission		£ 320	*per admission reduced*	*Based on OP1 cost*
	A&E		£ 90	*per attendance saved*	*Based on Crawley average*
	First Outpatient Appointments		£ 40	*per attendance saved*	*Estimate*
	Long Term Conditions		£ 204	*per admission reduced*	*Self care*
	Complex Patients		£ 884	*per admission reduced*	*Specialist unit*
	PBR Excluded Drugs (CCG)		£ -	*per £ saved*	*Estimate*
	PBR Excluded Drugs (SpecComm)		£ -	*per £ saved*	*Estimate*

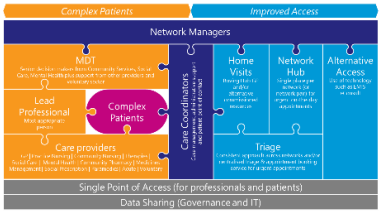
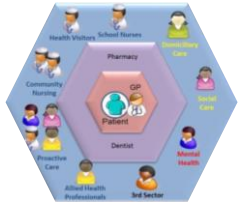
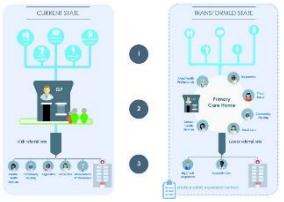
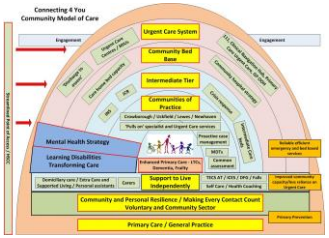
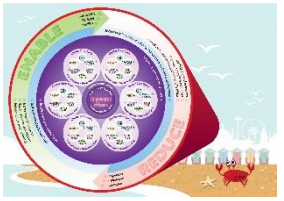
6 Net impact to financial position

Appendix B

Existing primary care development projects

How each CCG is currently developing primary care

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

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

Appendix C

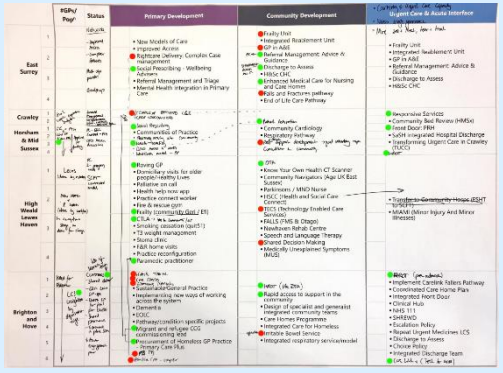
Parties involved in developing this plan

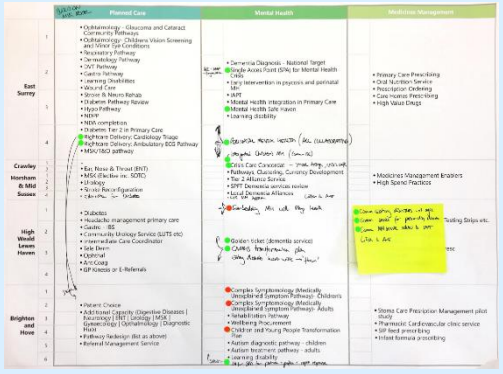
Workshops

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

CCG integration leads

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





Providers

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

GPs

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