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05 November 2020

Dear Member,

Health and Adult Social Care Scrutiny Committee - Wednesday, 11 November 2020

Please find enclosed the following documents for consideration at the meeting of the Health and Adult Social Care Scrutiny Committee on Wednesday, 11 November 2020 which were unavailable when the agenda was published.

Agenda No	Item
5.	**Primary Care Restoration and Future Planning in West Sussex Appendices A - G** (Pages 3 - 100)

Yours sincerely

Tony Kershaw
Director of Law and Assurance

To all members of the Health and Adult Social Care Scrutiny Committee

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Healthwatch in Sussex and Sussex NHS Commissioners

Accessing health and care services – findings during the Coronavirus pandemic: Executive summary

October 2020

Contact – Dr Lester Coleman

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Contents

Accessing health and care services – findings during the Coronavirus pandemic – Executive Summary

Introduction

This report, a collaboration between Healthwatch in Sussex[1] and Sussex NHS Commissioners, presents results of engagement carried out on people's preferences towards the future of health and social care services in Sussex. The analysis of 104 follow-up conversations is being undertaken at the time of writing and will be reported separately.

This engagement process looked at people's opinions about:

- Their access to health and social care services during the Coronavirus pandemic (and whether they have delayed this as a consequence);
- Their use of 'remote[2]' or phone, video and online appointments with health and social care services during the pandemic; preferences for the future use of these media for appointments beyond the pandemic; and
- Preferences towards future GP consultations.

Data on equality and diversity were also gathered. This project was supported through grant funding from the NHS Brighton and Hove CCG, East Sussex CCG and West Sussex CCG.

The engagement builds on two additional Healthwatch projects conducted across Sussex. Firstly, 970 responses from 11-18 year olds and 1209 responses to an adult survey is conducted by Healthwatch East Sussex and, secondly, findings from a number of young people interviewed about their experiences of digital/remote consultations during the pandemic undertaken by Healthwatch West Sussex[3].

Methodology and engagement

The principal method of engagement was a questionnaire consisting of mainly closed, fixed response questions, occasional free-text responses and some follow-up phone conversations for those who volunteered. Some of the same questions were used in a separate Sussex NHS Commissioners' survey, allowing the responses to these particular questions to be combined and analysed collectively.

In total, 2185 people responded to the two surveys as follows (an additional Young Healthwatch Sussex survey, with a total of 146 respondents aged 13-25 [average 18.33 years], will be published October 2020):

- Healthwatch in Sussex survey – 1406 respondents (June 16th to July 15th 2020)
- Sussex NHS Commissioners' survey across Sussex – 779 respondents (June 23rd to July 10th 2020).

[1] Healthwatch in Sussex is Healthwatch East Sussex, Healthwatch West Sussex and Healthwatch Brighton and Hove working in collaboration.
[2] The term 'remote' is used interchangeably with 'digital' and refers to non-face-to-face appointments. This is either phone, video or online (text, email or other online).
[3] https://spark.adobe.com/page/bv91D8t1FSZ37/

The surveys were promoted in a number of ways including Healthwatch mailshots to local networks and contacts, Brighton and Hove City Council COVID-19 briefings, by the three CCGs via their public bulletins and their websites, Facebook communities, other social media, and supported by a high visibility on the websites of the three Sussex Healthwatch organisations and email signatures.

The data were analysed in SPSS (Statistical Package for the Social Sciences) exported from Survey Monkey. The Healthwatch and CCG data were merged where questions were exactly the same in both surveys. As shown above, the merged data had a sample of 2185; the data not merged between the two surveys had a sample of 1,406. The analysis consists of 'valid cases' i.e. derived from all those that replied to a question (excluding missing cases) and where questions were applicable. For example, the proportion of people having a GP appointment by phone would only apply to those that had any type of phone call appointment during the pandemic. Open-ended comments were analysed thematically and help to explain some of the quantitative findings.

Engagement findings

The people:

The location of respondents was broadly similar across the three Healthwatch areas: Brighton and Hove (32.2% [447]), East Sussex excluding Brighton and Hove (32.1% [445]), and West Sussex (35.7% [495] - less than a four percentage-point difference across the three areas).

Excluding 'prefer not to say', most people responding were women (75% [1448]) and the average age was 59.2 years.

Alongside age and gender, differences in the findings were examined across:

- people with disabilities (39.2%[4] [599] - 14.5% [222] 'a lot'/24.7% [377] 'a little') compared to those without;
- Black and Asian Minority Ethnic groups (comprising 10.9% [164] of the sample) compared to White British; and
- those who identified themselves as Lesbian, Gay or Bisexual (7.4% [107]) compared to those who identified themselves as heterosexual.

Where differences were revealed, those by disability and age were the most frequent and there were notably very few differences by ethnicity.

It should be noted that there were people and communities who were not represented in this work; further engagement will be carried out to establish views and experiences, which will be added to this intelligence.

[4] The precise question was 'Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?'

Key headlines:

37.4% [806] chose not to make an appointment during the pandemic despite having a need to access health, social or emotional care.

People with disabilities were more likely to delay making appointments. Women were more likely to delay making appointments compared to men.

For those that had phone, video and online appointments during the pandemic, satisfaction levels were high.

People with disabilities and Lesbian, Gay and Bisexual people were generally the least satisfied with appointments during the pandemic.

For triage, GP appointments, getting medication or a repeat prescription, receiving test results and appointments for emotional and mental health NHS wellbeing support (including counselling and therapy), people were mostly keen for phone appointments relative to video and online.

A high proportion of people who were not happy to receive any form of remote appointment for their mental health.

People with disabilities were significantly less happy to have any type of remote GP appointment, independent of their ethnicity, gender, sexual orientation, and age.

When controlling for the effects of other factors, younger people were generally happier to receive an outpatient appointment by video compared to older people.

Older people showed strong agreement to preferring face-to-face appointments with their GP. Younger people were happier to have a phone or video appointment with their GP.

People with disabilities were more likely to agree with statements that reflected this groups overall dissatisfaction towards remote appointments with their GP.

Older people showed more importance towards having a phone and/or video appointment with their regular GP.

Younger people showed more importance to being able to book a phone and/or video appointment via an online booking method rather than by phone; being given the choice between having a phone or video appointment; and being able to upload photos of their condition to a GP.

People with disabilities showed more importance towards phone or video appointments with their *regular* GP and less importance towards phone or video appointments as soon as possible with *any* GP.

People with disabilities showed less importance towards being able to upload photographs of their condition.

Women showed more importance towards phone or video appointments with their *regular* GP. Women showed more importance towards being given a choice of phone or video appointments with their GP.

People describing their day-to-day activities as being limited ‘a lot’ were more likely to delay their appointments; more likely to have appointments during the pandemic but also found them the least satisfying; and particularly disinterested in remote appointments (more interested in face-to-face).

People choosing to delay appointments:

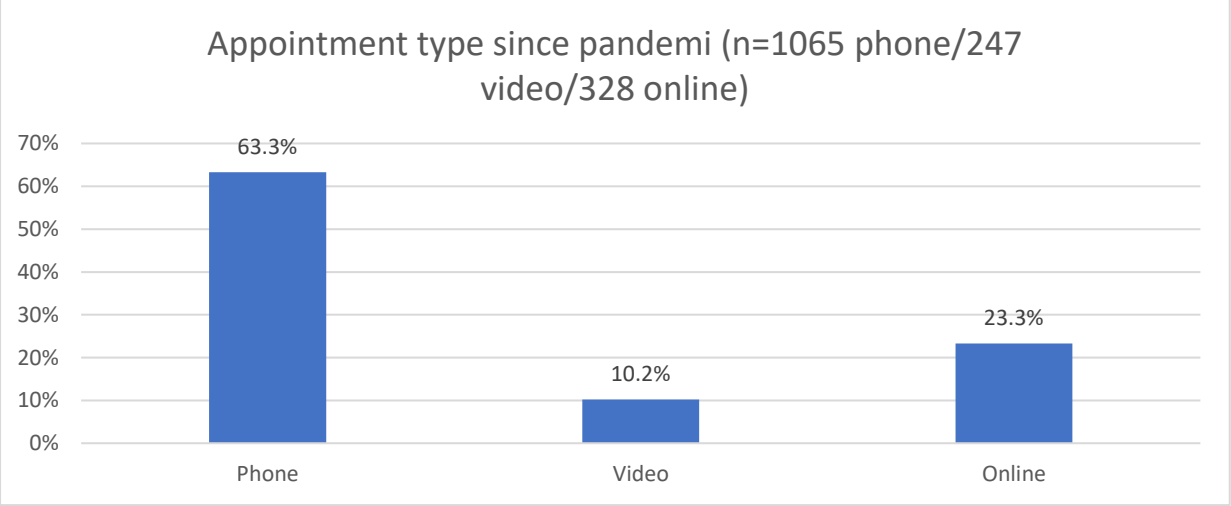
37.4% [806] chose not to make an appointment during the pandemic despite having a need to access health, social or emotional care. From all those that delayed their appointment, the top three reasons were:

- 'Felt that my condition wasn't serious enough' – 41.5% [396]
- 'Didn't want to burden the NHS' – 37.7% [360]
- 'Thought I'd wait until the pandemic was over' – 26.7% [255].

People with disabilities were more likely to delay making appointments relative to people without disabilities, independent of their age, gender, ethnicity, and sexual orientation ($p<0.001$)5. Also, women were more likely to delay making appointments compared to men ($p<0.05$), once ethnicity, age, disability, and sexual orientation had been taken into account.

Appointments during the pandemic – type and satisfaction:

During the pandemic, nearly two-thirds (63.3% [1065]) of people had a phone appointment, with lower proportions using online (23.3% [328]) and video (10.2% [147]). For interest, the CCG sample showed that 35.4% [297] had experienced a face-to-face appointment during the pandemic, the majority of which were at a GP surgery or at hospital.

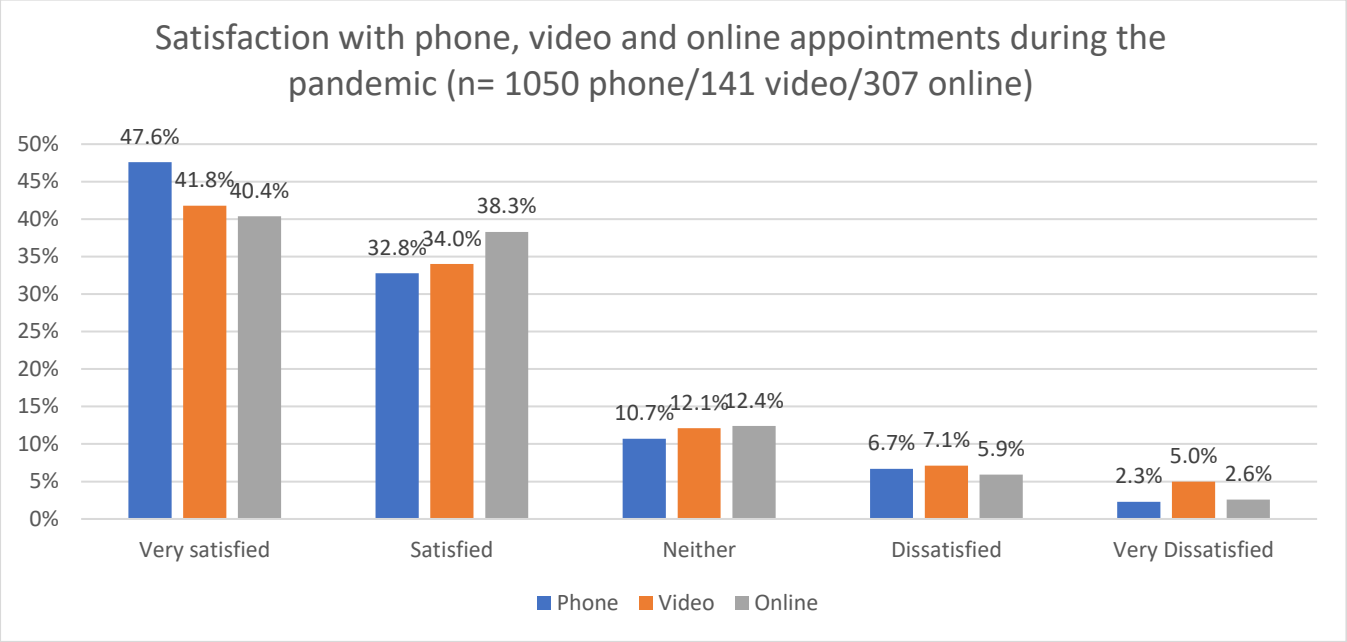


The most common appointments attended remotely, for all three formats (phone, video or online), in decreasing order, were with a GP, as an Outpatient, and phone questions from a health professional (e.g. Receptionist, NHS 111) to guide people to the right service. Appointments with a GP were twice as common as those for other appointments.

For those that had phone, video and online appointments during the pandemic, satisfaction levels were high. For example, 80.4% [844] were satisfied or very satisfied with phone appointments. This may show that if those people who were putting off appointments were encouraged to use this alternative provision, they may be more

[5] Where p values are shown this means the results are statistically significant – that means there is a high probability (99% in this instance) that the differences are not due to chance.

satisfied than they would initially expect to be. Nonetheless, around 10% were also not satisfied (for phone, video and online). The analysis reveals that people with disabilities and Lesbian, Gay and Bisexual people were generally the least satisfied with appointments during the pandemic.



"[Phone appointment] A lot easier than travelling to the hospital. It was quick and easy to arrange a phone appointment with my GP and I preferred it. It saved me time and money and I felt less anxious." **Man, aged 55, with disability.**

"Spoke with GP and condition was serious enough that she needed to see me for herself, but as I am immunocompromised and shielding I could not see her in person. I received a text with a link to click and that took me straight into a video chat with her all-in seconds. Easy, convenient and highly effective." **Woman, aged 36, with disability.**

Preferences towards future appointments during 'life after the pandemic':

In terms of future appointments, people were asked to say whether they were 'happy' with phone, video, and online appointments, or not happy for any type of such appointments. Not happy with any form of remote appointment would suggest greater happiness for face-to-face appointments. The most commonly used services have been compared as well as two focusing on mental health.

For triage (being guided to the right service), GP appointments, getting medication or a repeat prescription, receiving test results and appointments for emotional and mental health NHS wellbeing support (including counselling and therapy), people were mostly keen for phone appointments relative to video and online.

An interesting finding was the high proportion of people who were not happy to receive any form of remote appointment for their mental health - 29.7% [298] were not happy for any type of remote emotional and mental health NHS wellbeing support, including counselling and therapy; 43.6% [378] were not happy for any type of remote NHS mental health support for longstanding and serious mental health conditions).

GP, happy by *phone*	GP, happy by *video*	GP, happy by *online*	GP, *not happy for any remote*
70.9%	60.7%	34.8%	19.1%

Outpatient, happy by *phone*	Outpatient, happy by *video*	Outpatient, happy by *online*	Outpatient, *not happy for any remote*
52.6%	54.2%	28.5%	30.1%

Triage, happy by *phone*	Triage, happy by *video*	Triage, happy by *online*	Triage, *not happy for any remote*
87.0%	48.9%	54.2%	6.5%

Medication or a repeat prescription, happy by *phone*	Medication or a repeat prescription, happy by *video*	Medication or a repeat prescription, happy by *online*	Medication or a repeat prescription, *not happy for any remote*
77.9%	45.9%	71.0%	2.7%

Test results or screening, happy by *phone*	Test results or screening, happy by *video*	Test results or screening, happy by *online*	Test results or screening, *not happy for any remote*
71.5%	49.7%	50.6%	13.1%

Emotional and mental health NHS wellbeing support including counselling and therapy, happy by *phone*	Emotional and mental health NHS wellbeing support including counselling and therapy, happy by *video*	Emotional and mental health NHS wellbeing support including counselling and therapy, happy by *online*	Emotional and mental health NHS wellbeing support including counselling and therapy, *not happy for any remote*
52.9%	50.7%	27.0%	29.7%

NHS mental health support for longstanding and serious mental health conditions, happy by *phone*	NHS mental health support for longstanding and serious mental health conditions, happy by *video*	NHS mental health support for longstanding and serious mental health conditions, happy by *online*	NHS mental health support for longstanding and serious mental health conditions, *not happy for any remote*
42.0%	42.2%	23.2%	43.6%

In general, most differences in preference towards remote appointments were shown in terms of disability and age. For the two most common services (GP and outpatients' appointments) there are some differences by disability and age.

- People with disabilities were significantly less happy ($p<0.005$) to have any type of remote (phone, video or online) GP appointments, independent of their ethnicity, gender, sexual orientation, and age.
- Likewise, when controlling for the effects of other factors, younger people were generally happier to receive an outpatient appointment by video ($p<0.001$) compared to older people. Similar age patterns emerged for GP appointments.

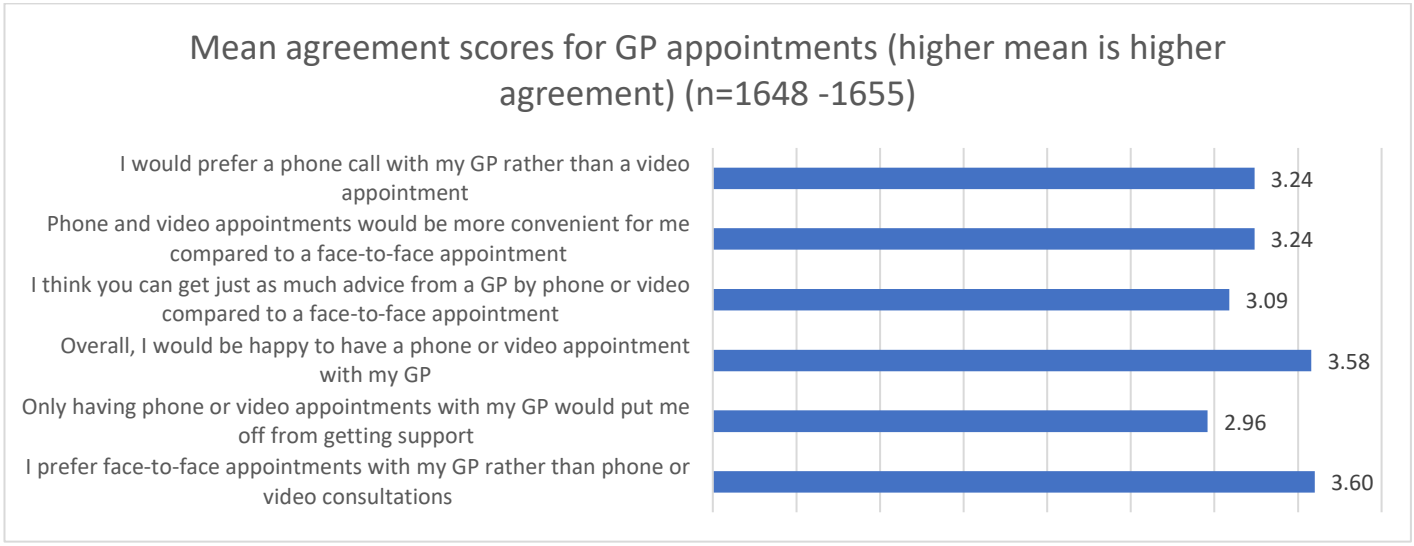
There were very few differences in the findings identified by gender, ethnicity, or sexual orientation.

"It's [remote] less personal and as an autistic person adds an extra level of stress to the interaction. It's harder to read body language over video and also on phone/'video it's harder to follow the conversation and know when it's my turn to speak." **Woman, aged 44, with disability.**

"I don't think it appropriate to deal long term with matters relating to mental health by phone, video or other remote means. It's fine for arranging and confirming appointments. But people suffering from mental health related matters need to now they are valued and their health issues and problems are being taken seriously." **Man, aged 71, without disability.**

Future GP appointments by phone, video and online:

People were provided with a range of questions about phone, video, and online GP appointments. From a five-point scale of agreement, the following mean scores show how this varied (from a minimum of 1 (strongly disagree), maximum of 5 (strongly agree), with higher scores indicating higher level of agreement). There are polarised views (see below) with the highest levels of agreement being 'happy to have a phone of video appointment with my GP' and preference towards 'face-to-face appointments with my GP rather than phone of video consultation'.



These polarised viewpoints suggest different preferences across the sample. There were notable differences by age and disability:

- Older people showed stronger agreement to preferring face-to-face appointments with their GP ($p<0.001$).
- Younger people were happier to have a phone or video appointment with their GP ($p<0.001$); thinking you can get just as much advice from a GP by phone or video compared to a face-to-face appointment ($p<0.001$); and increased convenience towards phone and video appointments ($p<0.001$) i.e. younger people were more in agreement to these statements.

People with disabilities, as opposed to those without disabilities, were more likely to agree with statements that reflected this groups overall dissatisfaction towards remote appointments with their GP. This may explain the greater likelihood to delay appointments among those people with disabilities shown earlier:

- People with disabilities showed higher agreement towards preferring a face-to-face GP appointment ($p<0.001$) (relative to those without disabilities).
- People with disabilities showed higher agreement that only having phone or video appointments would put them off from getting support ($p<0.001$).
- People with disabilities showed less agreement towards happiness to have a phone or video appointment with their GP ($p<0.005$).
- People with disabilities showed less agreement that they can get just as much advice from a GP by phone and video (compared to face-to-face) ($p<0.005$).
- People with disabilities showed less agreement that remote appointments are more convenient than face-to-face ($p<0.01$).

Managing and arranging future GP appointments:

Further questions were asked about how important certain aspects of managing and arranging a GP appointment would be. These findings again show different preferences towards remote appointments by age:

- Older people showed more importance towards having a phone and/or video appointment with their *regular* GP ($p<0.001$).
- Younger people showed more importance to being able to book a phone and/or video appointment via an online booking method rather than by phone ($p<0.001$); being given the choice between having a phone or video appointment ($p<0.01$); and being able to upload photos of their condition to a GP ($p<0.001$).

Difference by disability were again evident, by comparing people with and without disabilities, in terms of:

- People with disabilities showed more importance towards phone or video appointments with their *regular* GP ($p<0.001$).
- People with disabilities showed less importance towards phone or video appointments as soon as possible with *any* GP ($p<0.01$).
- People with disabilities showed less importance towards being able to upload photographs of their condition ($p<0.05$)

There were also a number of gender differences:

- Women showed more importance towards phone or video appointments with their *regular* GP ($p<0.05$).

- Women showed more importance towards being given a choice of phone or video appointments with their GP ($p<0.001$).

Further subgroup analysis by disability:

The majority of the differences observed across the results were by disability. To examine this further, the data was analysed to look at differences in terms of whether people's day-to-day activities were affected 'a lot' or 'a little'; however it should be recognised that we cannot identify the 'type' of disability, which may be physical, sensory, learning or mental health related.

The overall pattern was that those affected 'a lot' showed stronger differences compared to those affected 'a little'. Nonetheless, responses from those with any type of disability were still different to those without any disabilities (whether higher or lower according to the above findings). For example, people describing their day-to-day activities as being limited 'a lot' were:

- Most likely to delay their appointments compared to those limited 'a little' and to those people without disabilities ($p<0.001$);
- More likely to have appointments during the pandemic but also found them the least satisfying; and
- Particularly disinterested in remote appointments (more interested in face-to-face services) suggesting face-to-face appointments are not only important for people with disabilities as a whole, but especially so for those affected 'a lot'.

Qualitative engagement:

Healthwatch in Sussex contacted 104 people who volunteered for a follow-up conversation about the survey (from the 213 who volunteered). Although some of these findings are presented in this report, the majority are due to be published in October 2020.

The purposive[6] selection ensured a varied sample in terms of the response to survey questions (in particular, preference towards and against remote appointments and for those who delayed appointments); location (across Sussex); age; gender; disability; ethnicity; and sexual orientation. Topics explored included whether the medical condition or need changed among those who delayed seeking health or social care services, and also understanding whether phone, video or online appointments may be more acceptable for certain medical conditions over others. A further theme explored what would help people seek help if some of the remote options were not preferable.

Conclusions and recommendations:

Based on the analysis of whole sample frequencies and differences across age, gender, disability, sexual orientation and ethnicity, this engagement proposes a number of evidence-based recommendations for the Sussex NHS Commissioners, as follows (more detail in the main report):

[6] A sampling technique to deliberately (or purposively) chose to include certain characteristics. This interview sample ensured the inclusion of those with different preferences for remote appointments, and variations in location, age, gender, disability, ethnicity, and sexual orientation. This contrasts to a random sample of interviewees where such variation may not be selected.

1. To further and strengthen the message that the NHS is ‘open for business’ and the ‘Help Us Help You’ campaign. There is a particular need to share these campaign messages among people with disabilities and women who are more likely to delay appointments when in need.

2. There is a need to ensure that communication is in appropriate formats, is received and understood.

3. Engage people with disabilities and women to better understand why they are more likely to delay remote appointments.

4. Make the public aware of the positive satisfaction ratings for phone, video, and online appointments, to encourage people not to delay appointments when in need.

5. Engage people with disabilities and Lesbian, Gay and Bisexual people to better understand why they are the least satisfied with appointments during the pandemic.

6. Offer a range of remote appointments, by phone, video and online (email, text and other online) given the public preference for a choice of remote appointments. Allow the patient to choose their preferred remote option.

7. Although the majority of people were generally happy to receive remote appointments, from a range of different services, they are not suitable for everyone and face-to-face options must continue. This is necessary for:

    - Certain health conditions where a face-to-face examination is required, or a where a health need is described by survey participants as ‘serious’.

    - Outpatient appointments and mental health support areas where there is a strong preference for face-to-face support.

    - People with disabilities and especially so for those affected ‘a lot’. Understand that people with disabilities are the least satisfied with remote appointments and are less happy to have remote appointments in the future.

    - Older and digitally excluded people who lack either the access, skills, confidence, or motivation to use remote technology with beliefs that such appointments are less effective than face-to-face.

    - Where individuals, such as young people, are unable to secure a private space to hold confidential conversations with health and care professionals.

    - The polarised opinions towards preferences for face-to-face appointments and remote appointments with a GP show a need for both options in future service delivery. Amongst older people, those with disabilities and for Lesbian, Gay and Bisexual people, there is a stronger preference for face-to-face GP appointments.

8. Allow patients the opportunity to choose a remote appointment with their regular GP if this is preferred.

9. Reduce the proportion of people who are digitally excluded and who will not use remote options, on the grounds of insufficient technology, internet connection or inability to communicate by such means.

10. Familiarise some older people, in particular, in how to use video and online services. Promote videos or other media to show the processes involved in having phone, video or online appointments to encourage their future use as well as ‘tips’ for effective engagement.

11. Health and care services to arrange remote appointments for specific times, rather than patients having to wait all day for a call-back.

12. Raise the skills of some health professionals in using the technology that is required for remote appointments.

13. Encourage men to seek mental health support when needed, to break down the perceived stigma and reluctance to open-up about mental health.

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Digital Innovation
Learning from residents

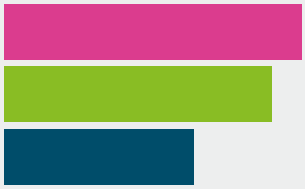
healthwatch in Sussex

We explored people's use and thoughts to inform the future use of digital access for health and care services in Sussex.

2,185 residents took part in online surveys and phone interviews during the COVID-19 pandemic/lockdown. (With responses fairly evenly split across Brighton & Hove, East and West Sussex).

Location of responders:

More than a third chose **not to** make an appointment during this time, despite feeling they had a need to access health, social or emotional care. Of these:



41.5% 'Felt that my condition wasn't serious enough'

37.7% 'Didn't want to burden the NHS'

26.7% 'Thought I'd wait until the pandemic was over'

People with disabilities were around **4 times more likely** to delay making an appointment compared to people without disabilities.

People's consultation experiences

63.3% of people had a phone appointment

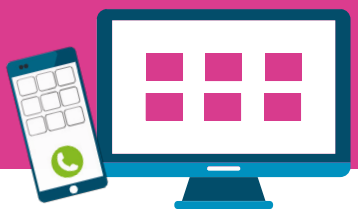
23.3% of people had an online appointment

10.2% of people had a video appointment

The most common appointments attended remotely were:

- with a GP
- as an Outpatient
- phone questions from a health professional (e.g. Receptionist, NHS 111) to guide people to the right service

Remote appointments **with a GP** were twice as common as those for other appointments.

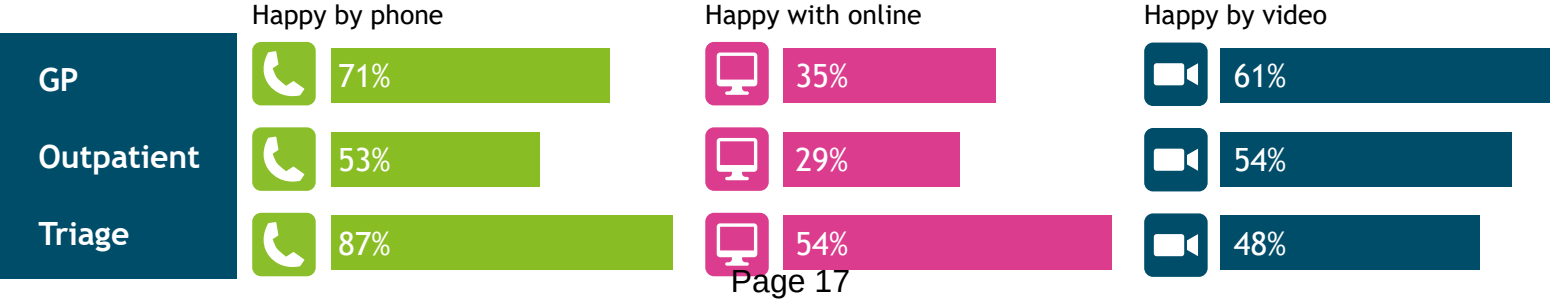


Overall, 63% agreed that they would be happy to have a phone or video appointment with their GP.

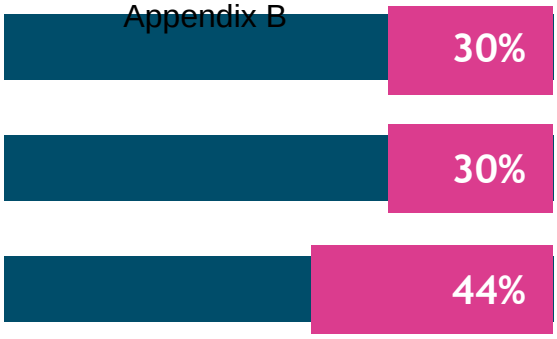
High satisfaction with remote consultations

Just over 7.5 (in 10 people) were satisfied with remote access.

People were generally happy to have remote appointments *in the future* but not for all services.



People with certain conditions are less happy accessing support digitally



did not want a remote appointment for emotional and mental health NHS wellbeing support, including counselling and therapy

did not want a remote outpatient's appointment

did not want a remote NHS mental health support for longstanding and serious mental health conditions)

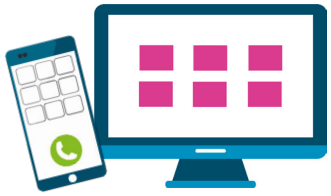
Age is also a factor

Generally, younger people **were happier** to have future appointments by phone, video or online, compared to older people.

> Spoke with GP… easy, convenient and highly effective

> Efficient focussed and effective, liked not having to travel

11-16 year olds experienced particular challenges with video and phone consultations, feeling anxious about privacy and lack of rapport.



Older people are significantly less happy but for different reasons - such as fear of technology, hearing loss etc.

People with disabilities are significantly less happy to have **any form** of remote appointments for:

- Being triaged
- GP appointments
- Getting medication or a repeat prescription
- Receiving test results or screening

Healthwatch is working with local partners to understand how people could be supported to be more digitally included.

Conclusion

Although the majority of people were generally happy to receive remote appointments, from a range of different services, they are not suitable for everyone and a hybrid model of delivery (remote and face-to-face) is recommended.

For research or data clarification please contact Dr Lester Coleman, Evidence and Insight Manager, lester@healthwatchbrightonandhove.co.uk 01273 234 041

To contribute personal experience to our evidence base:

Healthwatch West Sussex: 0300 012 0122
Healthwatch East Sussex: 0333 101 4007
Healthwatch Brighton & Hove: 01273 234 040

healthwatch in Sussex

How to build rapport and help health professionals communicate during a pandemic

Digital engagement with young adults (aged 16-19)

In October 2020 we had a focused discussion with 14 graduates and 3 youth workers from the National Citizen Service in West Sussex. Attendees were an even mix of male and female.

These are their thoughts and valuable suggestions.

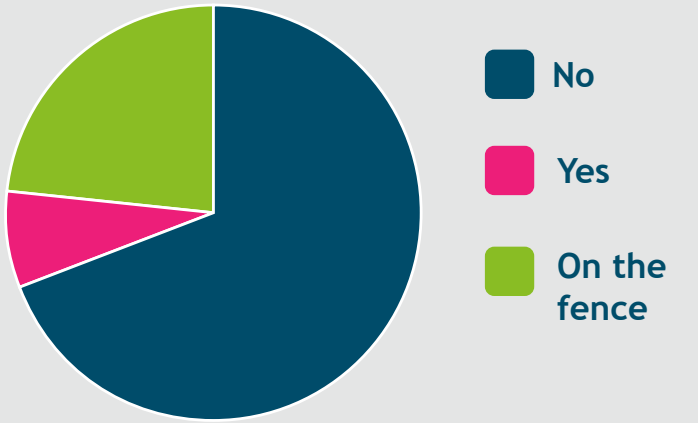
How to make digital more inclusive

- Need a timed appointment like face-to-face – as a patient needs time to prepare.
- Appointments should be longer than normal – need time to build a relationship as the normal welcoming social interactions that would happen when you enter the consultation room don't occur.
- Need time to describe the problem (this can be stressful, e.g. what if you don't get the words right?) With screens, you have to get them angled right so that you can show the problem. And things look different on the screens. But obviously, this could be tricky with the time constraints providers have.
- Friendly text/email before an appointment – a friendly hello and a guide to what to expect and what they expect would make things easier. This could include a hyperlink to a webpage with more information. This should include:
  - **Information** - Who will be in the consultation as the patient can't see who's in the room.
  - **Reassurance** - The only recording will be the notes on your medical records the clinician makes, and you can always get a copy of these – this is normal practice. We don't record our consultation in any other way.
  - **Advice** - There can be delays in sound and images – we are sorry if this happens and please don't worry that this is anything other than delays because of the technology. Please feel free to ask us to repeat things, or to let us know if we've misunderstood something. If a question makes you feel uncomfortable, say and we'll try asking for information differently.
  - **Requests** - We'll ask you to keep your video on, as this helps us to better understand your medical concerns.

- Clinicians should invite patients to say if they can't hear or see them clearly, and reassure that the questions being asked are to help them to understand a person's health and wellbeing needs better.
- When making a digital appointment, ask if it would be helpful to upload photos ahead of the appointment, but it's important to explain who will see these and why. For example, to show an infected area.
- Review if there are any restrictions on under 18s making an appointment online, and if there are, review if this is appropriate.

The young people took digital engagement to include any engagement that wasn't face-to-face. This included digital platforms, e.g. zoom, NHS digital consultation platforms, email, phone conversations etc.

Straw poll results - Do you prefer digital appointments to face-to-face?

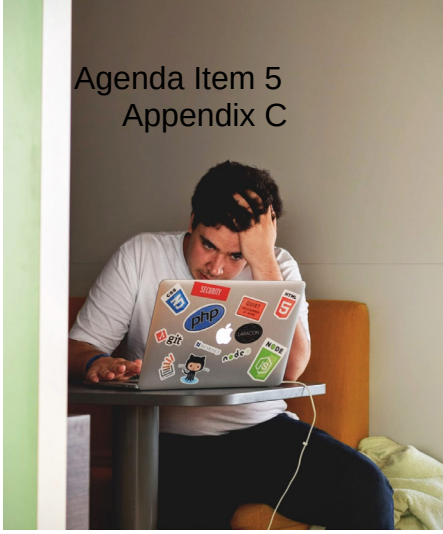


Positives

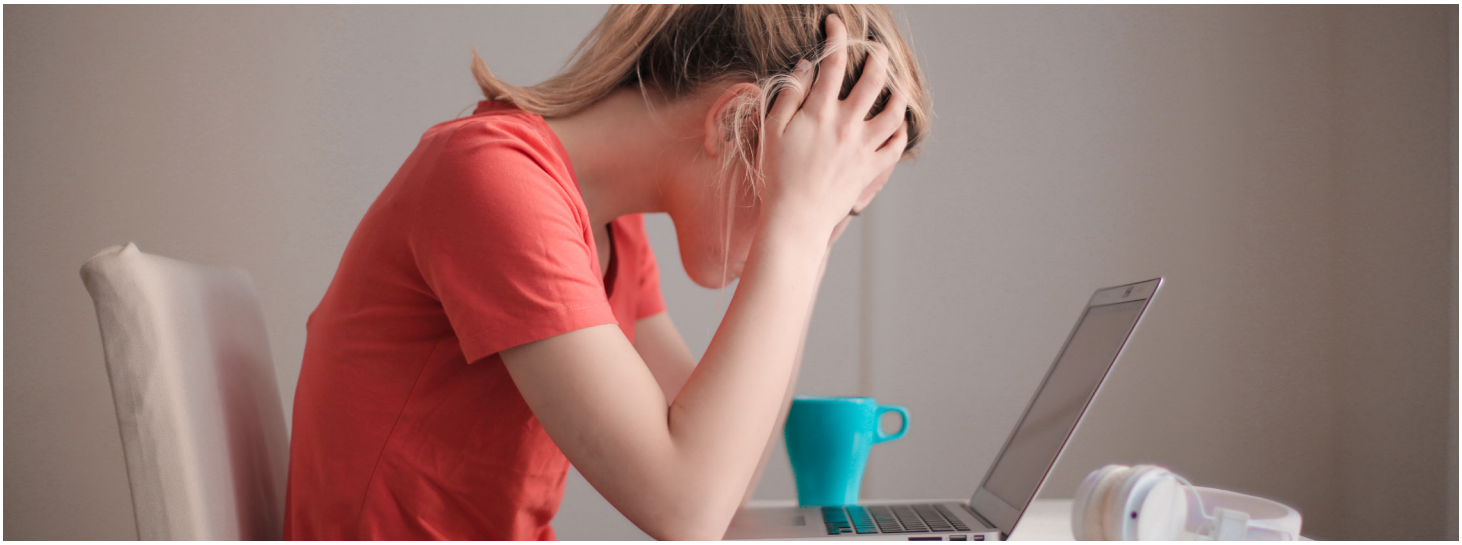
- Can be good for the older generation and those with mobility problems – can remove some of the physical barriers to accessing appointments.
- For many people, these forms of engagement may be more convenient and easier to fit in around people's lives. However, this was disputed later in the conversation, mainly due to phone appointments often being at some point today the doctor will call you basis, rather than for a time slot.

> **"I have a fear of needles and if a GP is online it makes me feel less scared as I know I won't be sent for a blood test that day and it gives me time to get myself ready for one, or an in-person talk."**

Negatives



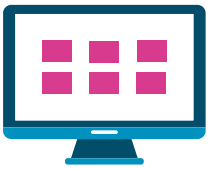
- Awkward to communicate, particularly about health issues, if you can't see someone's face. You don't know how they're responding/taking what you say.
- Can be hard to trust them – you don't know who else is in the room; who can hear what you're saying or see pictures etc. The group felt that they were more likely to trust a practitioner when they saw them face-to-face. And that this was harder to build via other engagement. **"You don't know who's there or if it's being recorded."**
- There are certain things where it would feel difficult to have a virtual consultation due to personal boundaries and the communication barriers, e.g. if it was a "female" issue (however the young men in the group also agreed), or cancer or something else "big". It wouldn't feel comfortable over digital.
- On the phone, you miss out on lots of visual clues which are important in assessing someone's wellbeing.
- Feel like there is more room for misunderstanding when an appointment is not face-to-face
- Feels more embarrassing as it's not the normal type of engagement and you don't know what to expect.
- It's hard to get an appointment – the phones are too busy. I've been trying to get through for weeks. And I can't make an appointment on the website as I'm under 18.
- The group agreed that they felt more "obliged" to answer a question when on the phone or a screen. In-person, they can use body language to answer or not.
- I don't really like video calls so I would personally prefer to go in person.
- I would agree especially for starting college. It's hard to focus online.
- I don't like video calls just because I tend to be awkward and worried about accidentally saying something wrong or having my camera on when I hadn't realised, etc. I just kind of get worried for more reason than I should be.
- There needs to be better communication between GPs, e.g. one GP prescribed me some medication, but when I had an appointment with a second GP they nearly prescribed the same thing again as it wasn't on the system.



Difficulties due to the technology

- Difficulties of virtual engagement can be emphasised by the delay in feedback – **"it can make you feel that you're wrong or being judged."** Can feel like **"they don't believe you,"** and that it's easier for misunderstandings, e.g. that they decide you're feeling or describing something else, not what you are feeling or describing". Harder to correct as the interactions aren't as natural.
- The difference in technology/data connection can create lags and uncomfortable pauses that make conversation difficult.
- Difficulties with equipment – can be hard sometimes to make the technology work. Do health care providers have back-up plans if this happens?

Mixed



- The fact that screens can be turned off was considered both a negative and a positive, e.g. can feel more comfortable if off, but equally can "hide" and necessary information missed by the health care provider. Body language is so important and can give much more information than words alone.

Experiences

- Acne consultation felt very difficult due to the screens – wanted that consultation to be face-to-face.

- Had a GP consultation on the phone but had to wait all day whilst at college. This meant I had to tell my teacher so I could leave the classroom. This was embarrassing, and it also meant everyone saw I had to leave. Knowing a time would have been useful so I could be prepared. Also a text or email introduction. It was all too unknown and quite nerve-wracking. Being in college with nowhere private added to that.
- We had to have a digital appointment for an infected insect bite, but the connection was really poor and kept cutting out. The appointment lasted for ages as it took a long time to upload photos and then wait for emails about medication etc. We didn't know if information had got through.

A big thank you from Healthwatch West Sussex to the NCS youth workers and grads who shared their experience and insights with us.

Primary Care Programme Assurance Briefing

Restoration and Recovery

Date:	4 November 2020
Version:	V2.1
Name of originator/ author:	Sarah Henley, Director of Primary Care

Contents

1.0 Executive Summary

The Joint Committee was provided with comprehensive updates in May and June on the delivery of the new service models implemented in response to the Covid-19 pandemic to support primary care providers and patients. The reports outlined a high level description of the actions taken to restore and recover services in response to the letter received from Simon Stevens and Amanda Pritchard on 29th April 2020 title 'Second Phase of NHS response to Covid-19. This letter has previously been shared with the Joint Committee and Governing Bodies of the three CCGs.

As previously reported, a range of changes were rapidly implemented in Primary Care to support safe delivery of care to patients including;

- Adoption of a total triage model
- Virtual consultation with the introduction of video conferencing facilities
- Establishment of hot sites / zones to enable the safe provision of face to face appointments when deemed clinically appropriate
- Support to vulnerable groups including home visits to patients with Covid-19 symptoms
- 100% coverage of a named clinical lead for each Care Home in Sussex
- Locally commissioned services including Discharge to Assess patients and Out of Hours provision.

Business continuity plans were updated for each practice, and practices were supplied with laptops / VPN to support virtual consultations. This also strengthened primary care resilience as staff were able to work remotely if required to self-isolate. A communication framework was established comprised of daily primary care bulletins and weekly joint CCG / LMC webinars to ensure clear points of contact and guidance.

This paper provides updates on developments since then and in particular the Primary Care response to the 'Phase 3' letter ('third phase of the NHS response to Covid-19 sent by Simon Stevens and Amanda Pritchard on 31 July 2020) previously shared with the Joint Committee in September.

The update covers details of:

- The restoration of primary care services in response to Phase Three letter
- Additional local commissioned primary care services
- Primary care winter seasonal plans
- Other primary care priorities
- Primary care Covid-19 related finances
- Delivery risks in Primary care
- The next steps.

2.0 Restoration of primary care services - phase three

2.1 Phase three requirements

The last update to the Joint Committee described the embryonic primary care programme plan to restore services in response to the phase 2 letter. The 'Phase 3' letter ('third phase of the NHS response to Covid-19) sets out the NHS priorities for CCGs and Providers to focus on from August 2020, as follows:

- Accelerate the return to near-normal levels of non-Covid-19 health services, making full use of the capacity available in the 'window of opportunity' between now and winter
- Prepare for winter demand pressures, alongside continuing vigilance in the light of further probable Covid-19 spikes locally and possibly nationally
- Do the above in a way that takes account of lessons learned during the first Covid-19 peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

2.2 Phase three requirements for Primary Care

The specific primary care requirements are as follows:

- **Restore activity to usual levels where clinically appropriate**, and **reach out proactively** to clinically vulnerable patients and those whose care may have been delayed.
- **Reduce unmet need and tackle health inequalities**, GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.
- GP practices need to make rapid progress in addressing the backlog of **childhood immunisations** and **cervical screening** through specific catch-up initiatives and additional capacity and deliver through their Primary Care Network (PCN) the service requirements coming into effect on 1 October as part of the Network Contract DES.
- GPs, primary care networks and community health services should build on the **enhanced support** they are providing to **care homes**, and begin a programme of structured medication reviews.
- CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. All GP practices must **offer face to face appointments** at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate – whilst also considering those who are unable to access or engage with digital services.
- In respect of support for people with a **learning disability**, autism or both, GP practices should ensure that everybody with a learning disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged.

2.3 Primary care restoration and recovery response:

The CCGs' Primary Care team have developed a detailed restoration and recovery plan in response to the 'Phase 3' letter. This plan, which is now being enacted and embedded, is built upon the NHSE/I South East Region strategic objectives, namely:

- The delivery of access to safe, high quality and effective services
- Capturing & building on innovation & transformation
- Six systems delivering world class, place based health & care
- A resilient, supported health & care workforce
- Financially sustainable systems.

To ensure delivery of the phase three requirements and the South East Region strategic objectives, thirty work streams have been developed each with agreed milestones and deliverables supported by clinical and managerial leads as appropriate. The work streams are categorised into three programme headings:

- General Practice
- Community and Joint Working
- Medicines Optimisation.

Each programme lead reports weekly to an oversight group (with PMO support) to ensure progress is maintained; all risks identified and mitigated against; and issues escalated when necessary for resolution.

2.4 Overview of restoration programme plan priorities

The table below summarises the most significant programme plan priority work streams established to restore general practice:

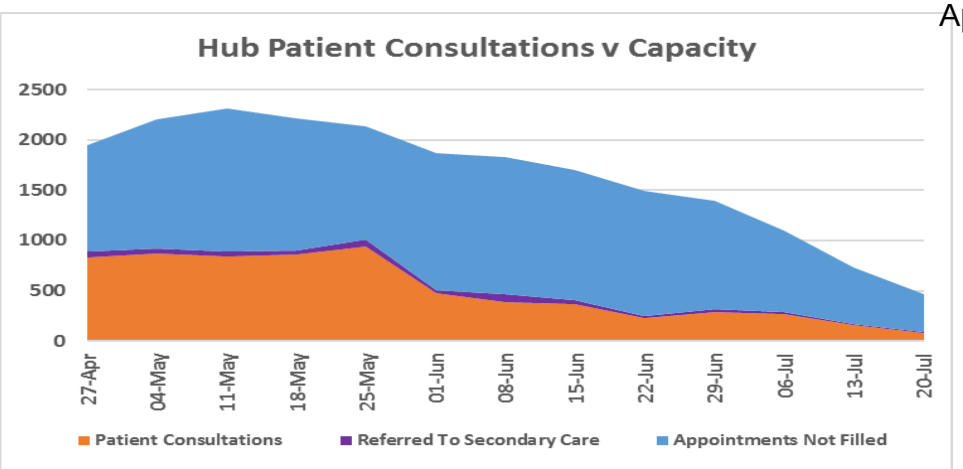
Programme	Work stream	Focus
General Practice	Hot sites / zones	The introduction of zoning and or Hot Sites to ensure the separation of hot and cold activity and the safe delivery of care for all patients is in place across Sussex. All practices have reviewed and adapted their plans to ensure that they are scalable to meet the demand of winter and Covid-19.
General Practice	Access to GP appointments	All practices are continuing to triage all patients to either a face to face or virtual consultation appointment as appropriate. Communication to patients to make them aware that they will receive a face to face appointment should they require one.
General Practice	Improved Access (I/A) service	Improved Access (I/A) services have been re-profiled across Sussex to ensure they meets the demands of the local areas as well as the contractual requirements of the DES requirements by 31/10/20. Notice has been served to the existing I/A providers as it the responsibility of PCNs to provide the service from 1 April 2021. .
General Practice	Restoration of activity	All practices have been restoring services back to pre Covid-19 levels. Overall harmonisation of LCSs across Sussex is taking place and an income guarantee for 2020/21 has been provided. High risk and vulnerable patients groups (Frailty, Cardiac, COPD, EHCH; and Diabetes) are prioritised.
Primary and Community	New Locally Commissioned Services	A number of new LCSs have been introduced to provide additional health care to support, these include: • BAME - for people who are at higher risk of complications resulting from Covid-19 • Out of Hours – enhanced clinical support to care homes with a proactive weekend 'check in' from practices to care homes • Temporary Residents placement – ensure the provision of primary medical care for patients who are discharged into

Programme	Work stream	Focus
		care home bed outside of their GP boundary
General Practice	Immunisation and Screening	Cancer (Bowel, Breast, and Cervical), Abdominal Aortic Aneurysm, Diabetic Eye, and Antenatal and New-born screening all have programmes in place and invitations have recommence and issued in priority order, from August 2020 onwards, supported by a full communications plan. The early cancer diagnosis DES went live on the 1st October
General Practice	Learning Disabilities	CCGs are below average for the Annual Health Check uptake. A plan to deliver Improvement Trajectories to target for Health checks for people with Learning Disabilities developed.
General Practice	Severe Mental Illness	Currently 30% of SMI patients received a Health check, trajectories are in place to reach the 60% target by March 2021 with a practice level plan to support delivery. This reports into the wider ICS Mental health collaborative.
Community Joint working	Enhanced Health in Care Home DES	All PCNs signed up to deliver the DES requirements. Multidisciplinary model for delivery developed with community providers and medicines teams. CCG Finance Director working with Community Trust FDs to source / identify funds to bridge the financial gap.
Community Joint working	Early Diagnosis Cancer DES	All PCNs signed up to deliver; baseline assessment survey completed; and support tools shared with PCNs.

2.5 Hot sites / zones

The CCG Primary Care Network (PCN) delivery managers worked alongside practices within each PCN to help support them in making the changes required to meet the new standard operating procedures (SOP) for general practice. The approach to enacting these requirements, in particular the separation of hot and cold patient cohorts, varied considerably across Sussex due the individual layout and associated estate issues of each practice. Some practices were able to establish distinct hot and cold areas within their practice buildings with little need for alterations and for most practices the requirements meant considerable upheaval and expense.

This pattern of provision was reviewed in July / August, due to a clear reduction in activity at the discrete sites, and a change in the funding criteria by NHS England. The reduction in activity is detailed below.



In July practices were asked to review their hot site / zone plans, and submit bids if additional funding was required to ensure they were scalable to meet the demands of seasonal winter and Covid-19 related illness.

An evaluation panel, made up of members from CCG primary care, NHSE/I, the LMC and a practice manager was put in place to review the plans received from practices. The outcome of this process resulted in the reduction in the number hot sites and an increase in the number of practices zoning.

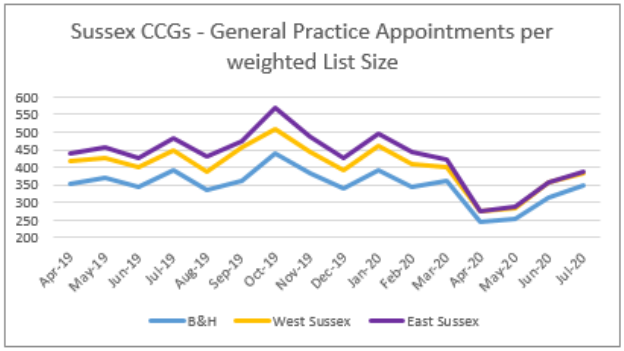
2.6 Primary care access

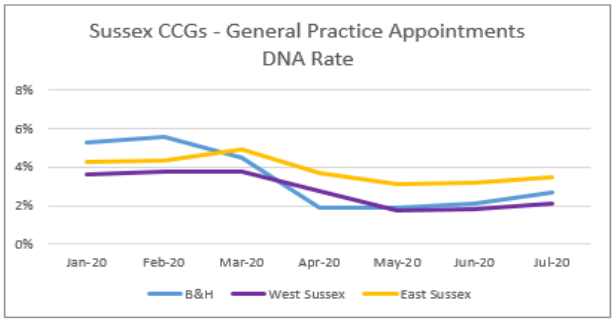
It is not a contractual requirement for general practices to routinely share capacity and demand information with its commissioners. Notwithstanding this, it is important to have a level of standardised information for planning locally commissioned services and for restoration purposes. To achieve this, the CCGs performance team have collated general practice and primary care data from the seven legacy CCGs to establish a baseline across Sussex.

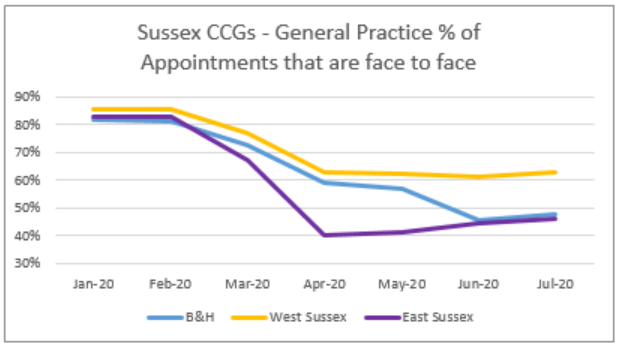
This information has formed the basis of a deep dive of primary care activity to enable a greater understanding of the activity about patients accessing general medical services during the pandemic response. It will also be used to benchmark activity and ensure that services are restored to pre-pandemic levels, while maintaining the significant improvements made in the availability of digital appointments which have been well received by a significant number of patients.

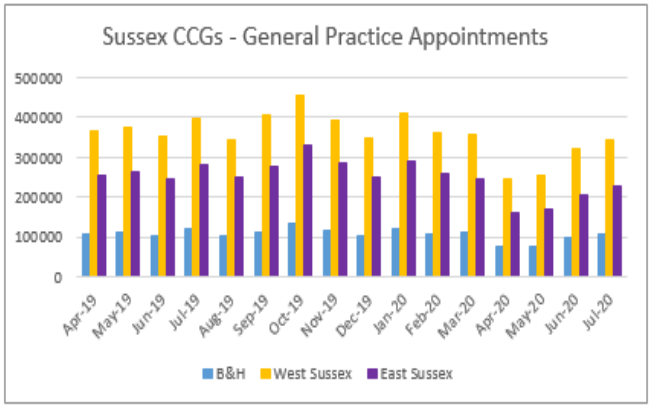
This information is provided at PCN and practice level which enable the PCN Delivery managers to work with outlying practices to understand the information and develop plans that start to address areas of challenge and variance.

The extracts from the deep dive below indicate that, as expected, the number of total appointments did reduce during the initial peak of the Covid-19 outbreak. This was in line with the picture nationally. Appointments are now returning to pre Covid-19 levels; virtual appointments have increased and Did Not Attend rates have decreased.









3.0 Additional commissioned services in primary care

3.1 Existing locally commissioned services (LCSs)

There are 32 LCSs in place across Sussex. However, due to the legacy CCG commissioning arrangements the content of the service specifications differ. A work programme to harmonise all LCSs has been developed with the engagement of the LMC, agreed by an LCS Restoration and Recovery group and ratified by the Primary Care Commissioning Committee (PCCC).

The initial focus is on the restoration of long term condition, care home, and frailty LCSs to develop a consistent Sussex wide service offer. The table below provides a timeline for the review of priority LCSs.

Area	Action	Sign Off / future plans
Diabetes	• Diabetes Task and Finish Group convened, including primary care diabetes leads, Diabetes commissioning lead, LMC • Agreed that harmonisation of all legacy Diabetes LCSs would start with the development of a Standard Operating Procedure (SOP).	• SOP sign off process: • LCS R&R Group on 15 July • Diabetes Task &Finish Group 17 July • Published 20 July 20, send to all practices • Launched with place based webinars Aug 20
COPD	• COPD Task and Finish Group convened August 20, comprising clinical leads, commissioning leads, and primary care clinical leads • SOP developed	• SOP presented at LCS Restoration and Recovery Group 2 September 20 • Webinar planned October 2020

Care Homes Frailty	• A number of legacy LCSs in place across Sussex including: ✓ BH – Enhanced Health in Care Homes LCS ✓ CWS – Quality Incentive Scheme ✓ EHS/H&R – Frail and Vulnerable Patients LCS ✓ HWLH – Enhanced Health in Care Homes ✓ CHMS – Care Homes LCS ✓ Covid-19 CH Support Model June 20 • Legacy LCSs served notice on with effect from 30 Nov • EHCH DES came into effect 1 October 2020 • Currently developing new frailty LCS to support the DES.	• Service specifications for new Care Home LCSs/Supplementary Commissioned Services shared with LMC for review, week beginning 12 October • Tariffs being costed, and meeting with LMC to agree week beginning 19 October • LCSs to go to PCCC November • To go live with effect from 1 December 2020
Heart Failure	• Heart Failure Task and Finish Group established • The Group has: • Undertaken a service mapping exercise • Linked in with KSS HF Collaborative • Committed to establishing primary care to secondary care pathway	• Aim to produce a referral pathway with a library of supporting documents and guidance. • To go live with effect from 1 December 2020

3.2 New locally commissioned services

The last report detailed the new LCSs that were being developed in response to Covid-19. These have now been commissioned and mobilised, as follows:

- Temporary GP Remote Out of Hours Cover for patients in Care Homes LCS provides enhanced clinical support to care homes outside of normal GMS hours – introduced in April 2020.
- Temporary Placements in Care Homes and other Community based beds (Sussex) LCS ensures the provision of primary medical care for patients who are discharged from hospital into a purchased community based bed (usually in a care home) during the Covid-19 emergency - started in April 2020.
- Specialist primary care and protect and support for homeless patients across Sussex providing proactive medical care for homeless people – introduced in May 2020
- BAME and Vulnerable Patients – Proactive health checks for people who are at higher risk of complications resulting from Covid-19 – started in June 2020.

The shielded patients LCS developed to ensure those patients who are shielded receive the care they need at home has not been introduced as the government guidance on shielded patients has changed. However, the funds for this LCS have been incorporated into the primary care financial stock-take and the LCS is ready to be introduced should the guidance change.

4.0 Winter planning in primary care

4.1 Governance

A task and finish group has been established to develop and implement a plan to ensure resilience in primary care services going into winter. This plan recognises the additional challenges to delivery resulting from social distancing to ensure that access to services will be maintained and undue pressure on the rest of the system avoided. This work has included the final arrangements for hot sites and zoning, alongside the review and harmonisation of long term condition LCSs across Sussex to ensure prioritised services for high risk patients. The final project plan has been agreed (7/10/20) and will be incorporated into the next iteration of the overall system plan which will be presented to the subsequent LAEDBs. Details of the plan are as follows:

Work stream	Area of focus	Status
Finalisation of plans for Hot zoning / sites	Ensuring practice resilience is maintained through the safe and effective management of existing estate; and remobilisations of hot sites as part of escalation triggers	Complete, subject to finalisation of escalation criteria
Prioritisation of restoration of LCSs for vulnerable patients /those at clinical risk	Cardiac, Diabetes, Enhanced Health in Care Homes, COPD, and SMI LCSs all restored – timetable for others in place.	Complete
Development of escalation criteria	Fifteen practices have been identified to pilot the Primary Care Data work offer real time activity data to contribute to system wide understanding of pressures in the system as we enter the winter period. This pilot will give a proxy RAG measure of daily pressures in General Practice.	30 October
Flu Vaccination	Flu plans have been agreed. A fortnightly Task and finish group reports to the Sussex wide Flu Board, and an internal operational group meets weekly to identify and address any immediate barriers to delivery. Demand and capacity exercise complete and circulated to practices.	Ongoing
Improved Access Appointments	During the pandemic Improved Access provision was profiled where appropriate to support hot sites and zoning. The CCG is now working with providers to return to previous delivery and utilisation. This will	30 October.

Work stream	Area of focus	Status
	enable flexibility of provision to respond to local seasonal demands at a place level.	
Enhanced Health in Care Homes	Sussex wide LCS to recognise and complement the PCN DES, and ensure a comprehensive and consistent level of support for these patients across the county	1 December
Fast track ARRS recruitment	Significant support has been provided to the PCNs to assist with their planning around ARRS through the Training Hubs and the primary care team, greater linking to national support needs to be delivered in particular the HEE Wessex WF tool and the NHS E/I recruitment support from NECSU. Locally owned support such as estates expansion and digital support for homeworking will be harnessed.	Ongoing
Walk-in Centres/Minor Injury Units	Full restoration of Walk in activity	Complete

4.2 Medicines Optimisation

The medicines management team is supporting the primary care restoration and recovery programme, including an agreed clinical service model for Enhanced Health in Care Homes from 01 October 2020. Sussex has 99.4% pharmacy coverage for the Community Pharmacy Consultation Service providing both "speak to" and "face to face" access to community pharmacy via NHS 111 Clinical Assessment Service and NHS 111 online. NHSE/I is making arrangements for a locally enhanced service that will cover pharmacies on Christmas Day for a three-hour session.

4.3 Influenza Vaccination

On 4 August 2020 NHSE/I and Public Health England announced an expansion of this year's Influenza Vaccination targets, raising the target to 75% of over 65s and at risk under 65s; and (subsequently confirmed as a second phase subject to vaccine availability) all 50 – 64 year olds. This presented challenges for General Practices due to the vaccine order having already been placed earlier in the year against previous targets; and the need to observe social distancing and other infection control guidelines following the advent of the pandemic which increases the time needed to vaccinate patients.

The CCG has been supporting practices to meet this target as follows

- Creation of a patient vaccination Task and Finish group, reporting to the Sussex Flu Board, to oversee progress towards the target. An internal operational group meets weekly to identify and resolve any immediate risks to delivery.
- At the request of this group the Local Medical Committee have published a seasonal Flu planning guide, with links to all relevant guidance, to help plan the operational aspects of their delivery programme

- Business intelligence has worked with practices to identify the potential shortfall in ordered vaccine and the desired target.
- Facilitation of discussions between PCNs and their community pharmacy colleagues to ensure a joint planning approach at a local level
- Creation of an on-line tool to identify any gaps in local provision, e.g. to care homes/other residential settings, which are referred to the Task and finish group for action.

Progress to date has been promising, with practices across Sussex already being halfway to target for the over 65s. However more work needs to be done with at risk groups as displayed in the table below:

CCG	65+ Registered	65+ Vaccinated	65+ % vaccinated	6m to 64 at risk Registered	6m to 64 at risk Vaccinated	6m to 64 at risk % vaccinated	Pregnant Registered	Pregnant Vaccinated	Pregnant % vaccinated
Brighton and Hove	26,587	7,263	27.3%	51,713	1,685	3.3%	517	25	4.8%
East Sussex	22,868	6,973	30.5%	23,054	945	4.1%	229	18	7.9%
West Sussex	120,457	46,174	38.3%	129,092	10,848	8.4%	1,679	231	13.8%
Sussex wide	**169,912**	**60,410**	**35.6%**	**203,859**	**13,478**	**6.6%**	**2,425**	**274**	**11.3%**

In terms of governance, more detailed reporting takes place separately through the monthly Task and finish group up to the Sussex wide Influenza Board and into the Sussex CCGs Joint Quality Committee. Further progress will be dependent upon the availability of additional vaccine, which has been ordered centrally and will be made available to practices in November. To prepare for this the CCGs are working with practices to understand the amount of additional stock required to reach target.

4.3 Seasonal escalation framework

The development of a seasonal escalation framework is key to support primary care winter planning for 2020/21 and aims to provide a greater understanding of historic and real time pressures on practices and provide a RAG rated measure of GP activity which will in turn inform a system response. Fifteen practices have been identified to be part of a primary care data work stream to pull together existing datasets to identify demand and capacity challenges in primary care. It will also inform the development of a Winter Escalation and Command and Control Framework, similar to the rest of the system, which will state a set of operational triggers (reported by practices to the CCGs in real time) which will then result in a range of ameliorative actions. This will be presented to the November Primary Care Commissioning Committee, and subsequent LAEDBs, for approval. Initial responses to such triggers being explored are as follows.

- Cross practice support for clinical face to face appointments.
- CCG communications support in terms of letting patients know the situation
- Increase and/or redeploy improved access capacity
- Direct redeployment of Improved Access staff to a challenged practice
- Increase and/or redeploy other contracted services- e.g. Brighton Roving GP/IC24/IPC/Practice assist
- Cross cover of admin staff/receptionists
- Engage GP Federation/PCN/ other provider support
- Funding for locums to increase capacity.

5.0 Other primary care priority areas

Alongside the restoration of general medical services to pre Covid-19 levels and the implementation of phase three requirements there are a number of other areas of priority that primary care are focussing on.

5.1 Primary Care Networks DES specification

All practices have signed up to deliver the PCN Network DES for 2020/21. Workforce plans have been developed describing which Additional Roles and Responsibility schemes (ARRS) PCNs will recruit to for 2020/21 and have also submitted business cases for the ARRS 2019/20 underspend. The CCG have supported PCNs to recruit into to the ARRS roles and agreed processes to administer both the under-spend for 2019/20 and the unclaimed funds for 2020/21.

The Enhanced Health in Care Homes and Early Cancer Diagnosis DES specifications also went live on 1 October 2020 and the CCGs are supporting providers to establish the MDT approach at PCN level. PCN Delivery Managers are also supporting PCNs to prepare for the requirement for PCNs to deliver the Improved Access requirements from 1 April 2021.

5.2 Primary / secondary care Interface

The Primary Quality Intelligence Tool (PQIT) Soft Intelligence Function is used by GP practices to raise provider interface and patient pathway issues in themes and trends relating to systems and pathways, and report these to the commissioners for analysis and action as appropriate to ensure that commissioned services are providing optimum services. A proactive process led by the CCGs Local Medical Directors and supported by the CCGs Quality team has been established with the Provider Medical Directors to review the themes emerging from PQIT and identify solutions to address them. Summary analysis of usage and key themes and actions will be provided to all GP Practice staff and at regular intervals via the monthly CCG newsletter, CD and Locality meetings.

5.3 Primary care engagement

The communication framework which comprises daily primary care bulletins to ensure clear points of contact and guidance and weekly CCG / LMC hot topic Q&A webinar continue. The CCGs primary care team also meets fortnightly with PCN Clinical Directors from each CCG to support PCN development, discuss initiatives to improve resilience and restore services, and identify and respond to areas of concern.

Locality Forums have recommenced. The initial round of Locality meetings have focused on transactional items such as agreeing the terms of reference of the group, the timing and frequency of the meetings and getting to know the new Governing Body Locality Representatives and lay members. The future agendas will be led by the Locality and the primary care team will present the Primary Care Recovery and Restoration and Seasonal Winter plans as part of the CCG standing agenda item.

6.0 Next Steps

The NHSE/I Phase 2 and 3 letters have provided a steer as to what services must be reinstated to pre Covid-19 level. The Primary Care team will continue to implement the activities described in this paper to ensure the following

- All patient services in General Practice are restored to pre-pandemic levels wherever possible
- Variation in service delivery as a legacy of the previous CCGs footprints is identified and resolved, resulting in a consistent high quality offer across the county
- Robust winter planning is in place and implemented to ensure resilient General Practice. These plans will include agreement of a set of escalation triggers and responses, including the potential mobilisation of hot sites; the temporary suspension of non-essential services and care in order to prioritise the vulnerable and frail population, should the need arise; and/or the repurposing and use of locally contracted services such as I/A and extended hours.
- Following the planning and implementation hiatus caused by the pandemic, Primary Care Networks are supported to move to agree and implement at pace their strategic plans to improve the health of their patient population.
- Any additional workload placed upon primary care through changes in secondary care activity are identified and resolved as part of a joint system response.
- Continued oversight of the Recovery and Restoration work programmes to ensure delivery.

7.0 Conclusion

Significant progress has been made since the June report in respect of the planning and preparations undertaken to ensure resilience of general practice and primary care throughout the winter and the safe and equitable restoration of services for patients in terms of access and availability.

It must be noted, that whilst primary care continues to restore its services to pre-COVID-19 levels, these will need to be reviewed and reprioritised in the event of a substantial second wave of COVID-19 and / or peak in seasonal demand.

Primary Care Restoration and Recovery Programme

West Sussex

11th November 2020

General Practice Restoration & Recovery Framework

The SE Regional vision

In restoring & recovering services we will take the opportunity to lock in the positive gains made during the response phase and drive transformation at pace to deliver high quality, clinically and financially sustainable services, improving outcomes for our populations, driving down health inequalities, with a focus on the most vulnerable

We will focus on 5 strategic objectives

Delivering access to safe, high quality & effective services	Capturing & building on innovation & transformation	Six systems delivering world class, place based health & care	Resilient & supported health & care workforce	Financially sustainable systems
SRO: TBC Lead: TBC	SRO: TBC Lead: TBC	SRO: TBC Lead: TBC	SRO: TBC Lead: TBC	SRO: TBC Lead: TBC
Deliver access to safe, high quality & effective services, through innovative service models that consider national & international best practice, appropriately reflect local need & factor in the ability to manage future surge pressures (Covid-19, Seasonal Flu)	**Capture and build on successful innovations implemented in the response phase** & fast track planned LTP transformation where appropriate to support system recovery	Six high performing systems, with their constituent organisations working seamlessly to provide **world class, place based health & care for their populations, focusing on the vulnerable.**	**Develop a resilient, flexible, inclusive and well supported health and care workforce** who feel valued and optimistic about a career in the NHS.	**Build financially sustainable systems**, maximising the efficient use of resources to deliver affordable, high quality, outcome focussed healthcare

To achieve our objectives we will work across a number of priority areas

1. Continue to safely reinstate General Practice services that were suspended during Phase 1; in particular, through LCSs or not, patients with:
   a) Long-term conditions; and
   b) Identified as Vulnerable
2. Consolidate 'hot sites' and create a plan for the continued usage during Phase 3 and beyond
3. Ensure a seamless transition of the current elements of the Covid Care Home Support into full specification delivery of the Network DES from October

1. Continue to closely review Digital First Primary Care (e.g. Total Triage and Remote Working) progress, and consider long-term implications of innovations
2. Share learning and best practice of Network-based approaches during Phase 1 & 2
3. Ensure Primary Care, Digital and Estates colleagues are strategically aligned in regards to long-term planning
4. Share learning and best practice to inform longer-term operating models as Networks of Practices

1. Deliver the early cancer diagnosis and SMR specs of the Network DES
2. Continue focus on Population Health Management (PHM) via the Aspirant ICS PHM Development Programme
3. For Phase 3, plan and ensure there is a Network approach to meeting Health Inequalities challenges
4. Once available, support implementation of recommendations of the Access Review
5. Support Systems with their PCN Development Support approaches for 20/21, ensuring continued investment against 19/20 'top 3 priorities'
6. Take an integrated approach across health & care, particularly partners in primary care, to the delivery of services e.g. homelessness & hard to reach communities

1. Continue to focus on PCN development, both the Clinical Directors and wider PCN teams, as part of PCN Development Support Programme
2. Continue to encourage PCNs to uptake ARRS roles
3. Map the wellbeing & resilience offers available to General Practice through Covid-19
4. Continue to support BAME workforce
5. Support Systems and Networks to convert seasonable GPs to substantive roles
6. Support Systems to develop and utilise their Training Hubs to support PCN workforce development

1. Introduce adjusted QOF payment for reminder of 20/21
2. Continue with GPFV investment
3. LCS Payment protection covering historic activity extended until the end of the financial year 20/21

General Practice Restoration & Recovery Framework

Sussex Primary Care and Community Services Workstreams

Delivering access to safe, high quality & effective services

1.Development of the place based Primary Care Strategy
2.General Practice consolidation of hot sites
3.LCS Service reintroduction and priority for harmonisation
4.Population based care and management of long term conditions – SOP, pathway refresh and referral improvement guidance to support the management of patients with Diabetes, COPD and Heart Failure
5.Flu programme
6. Winter Planning to manage demand and capacity

Capturing & building on innovation & transformation

1.Development of the local Covid Age tool, and aligned to the emerging national tool due Autumn
2.Prevention (improvement in uptake LD Annual Health Checks and Screening services)
3.Technology to enable care (Implementing the Covid Age Algorithm)
4.Quality education and sharing good practice
5.GPFV recovery plan (Inc. Improved Access)
6.Data working group identifying information extraction required to present a current picture of demand and capacity for Primary Care

Six systems delivering world class, place based health & care

1.Shielded and High risk patients
2.Additional General Practice support to Care Homes
3.Primary Care Networks
4.Additional Roles Reimbursement Scheme (ARRS) and work force planning
5.Pharmacy and medicines support to care homes
6.Early Cancer Diagnoses DES
7.Rollout of the RESPECT tool (interface with Planned Care)

Resilient & supported health & care workforce

1.BAME LCS
2.Shielded Patient LCS
3.SMI LCS review to improve uptake
4.Atrial Fibrillation LCS interface with Urgent Care
5.Quality education and sharing good practice
6.Membership engagement
7. Staff information and condition specific webinars

Financially sustainable systems

1.LCS Service reintroduction and harmonisation
2.Prescribing QIPP plan recovery
3.Prescribing incentive schemes re-introduction
4.Re-instigation of QoF reviews
5. Review of local incentive schemes e.g. QIS
6.Financial support and evaluation of Hot sites consolidation and zoning practices

Restoration and Recovery Phase 3

Implementing phase 3 of the NHS response to the COVID-19 pandemic published 7th August 2020 takes forward the ambition set out in the Phase 3 letter shared 31st July, specifically:

A Accelerating the return to near normal levels of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter

B Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally

C Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention

The 8 actions as set out are:

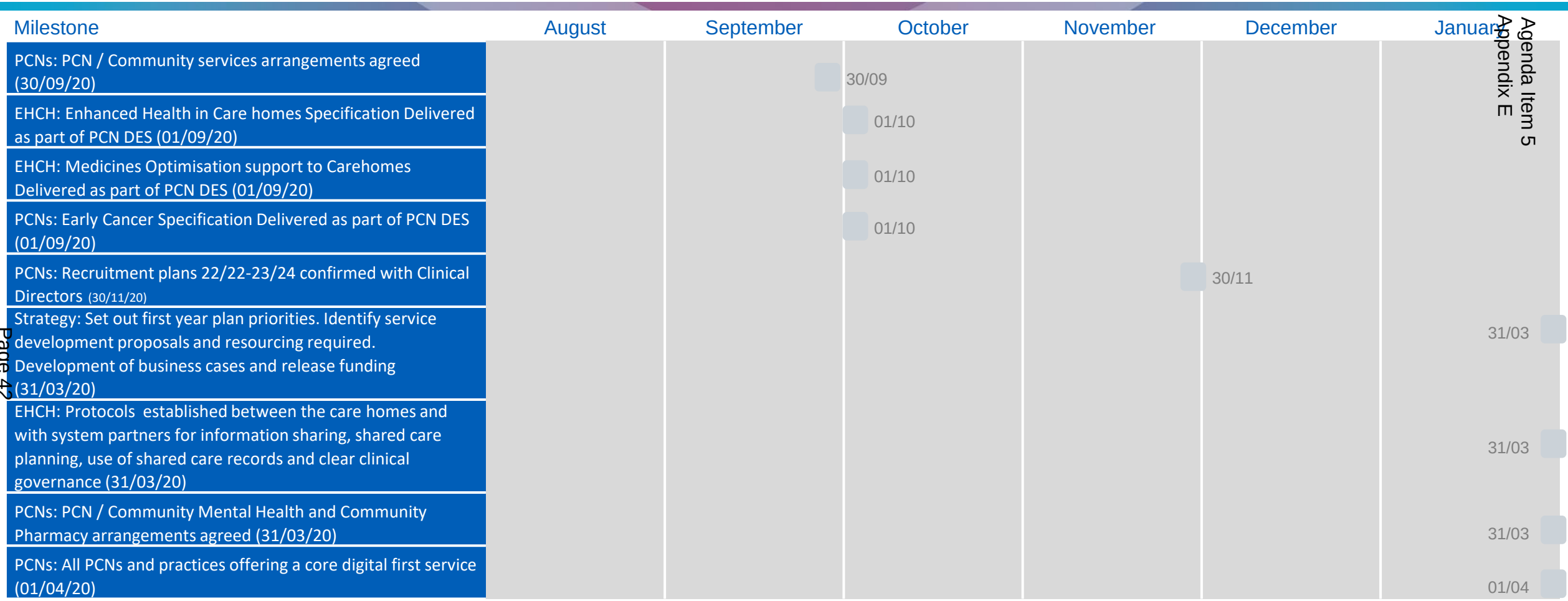
1. Protect the most vulnerable from Covid – 19
2. Restore NHS services inclusively
3. Develop digitally enabled care pathways in ways which increase inclusion
4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes
5. Particularly support those who suffer mental ill-health
6. Strengthen leadership and accountability
7. Ensure datasets are complete and timely
8. Collaborate locally in planning and delivering action

We are on track to deliver the strategic plan by 21st September and currently have 25 work streams within the Primary Care Programme

Recovery and Restoration Programme

	A. Primary Care & Community Services Joint Working	B. General Practice	C. Medicines Optimisation
Purpose / Description Of Programme	Enhance the current joint ways of working across Primary Care and Community Services. In addition, design and implement new joint ways of working as would be beneficial, initially with a focus on enhancing the system response to COVID. The programme will work with colleagues across multiple organizations involved in delivering these services, with general practice, SCFT and ESHT.	To develop a framework that describes a new model of care for general practice to consider. This will be based on what went well during phase 1 of COVID-19 and the guidance as set out in Simon Stevens letter. This programme recognises the interdependencies of other programmes and risks associated with the delivery of the programme.	To work with system partners to restore Medicines Optimisation Programmes and support delivery of patient-centred and population Medicine Optimisation through the CCG MO team and new pharmacy workforce in Primary Care Networks
Key Objectives	• Enhance existing joint ways of working between Primary Care and Community Service teams. • Explore opportunities to add additional joint working arrangements for the benefit of the system. • Ensure a consistent and joined up response to Shielded Patients across Primary Care & Community Services. • Take forward the implementation of the national Care Homes specification against the revised timelines requested by NHSE.	• To describe a new norm in ways of working based on local best practice for general practice with general practice • To be clear on expectations for patients in accessing services • To increase the scale and pace of progress in reducing health inequalities and regularly assess progress	• Engaging the Primary Care Networks on the implementation of the Medicine Optimisation elements of the DES from 1st October 2020. • The suspended QIPP programmes and prescribing incentives will be reviewed to agree appropriate levels of restoration (Oct – Mar 21) • Transformation of local decision-making on medicines • Aiming to have an aligned Integrated Medicines Optimisation Strategy from 1st April 2021.
Expected Outcomes / Benefits	• Enhanced health and care outcomes, more efficiently delivered across Primary Care & Community Services. • Consistent implementation of national guidance across Sussex. • Future, sustainable benefits beyond the COVID response as a result of joined up team working enhancing service delivery.	• General Practice supported to deliver Phase 3 of the national COVID response. • General Practice setup to deliver effective and efficient care in the context of the 'new normal' model of operation.	• Improved Primary Care quality and resilience • Improved patient safety and outcomes. • Improved efficiencies to the Primary Care Prescribing budget

Critical Path - Primary Care and Community Services – Joint Working

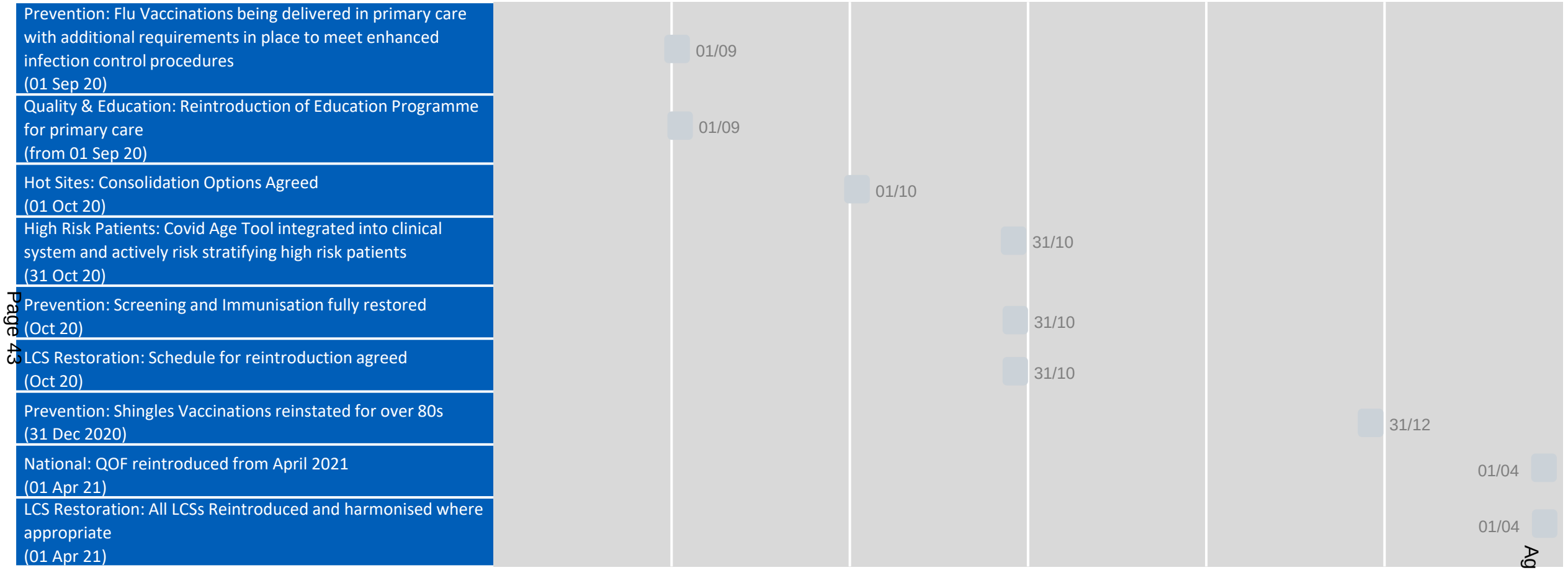


Existing service restored or new service commenced

Milestone

Dependency

Critical Path - Primary Care and Community Services – General Practice



Existing service restored or new service commenced

Milestone

Dependency

Closed Work streams and Projects
Celebrating Success

Date agreed as closed by Oversight Group	Project	Original objective	Outcome
7th Aug 2020	BAME LCS	Introduce an LCS to maximum possible practices to provide additional healthcare support to BAME residents who are at higher risk of complications resulting from Covid.	Delivered
7th Aug 2020	Shielding LCS (High Risk Patients)	Introduce a home visiting LCS for practices to provide healthcare to patients who are nationally recorded as shielding, and under non - Covid conditions would use public transport.	Delivered and ready to be stood up in the event of resurgence
August 2020	Diabetes Standard Operating Procedure	To provide clinical guidance for General Practice when managing people living with Diabetes during the Covid Pandemic. Next step to update and harmonise the existing Diabetes LCS specifications across Sussex in response to Covid to support this clinically vulnerable population.	Delivered
19th Sept 2020	Consolidation of hot sites	To review and agree the provision to manage patients in general practice who have diagnosed Covid or Covid symptoms - The work stream established the operating model design for General Practice moving forward in the context of the ongoing pandemic response. - Support to hot sites and zoning practices is ongoing	Delivered

General Practice

Sussex wide

Objective: to review the LCS, the activity and payment mechanisms for this service and to produce an action plan to improve delivery. This may include the option to commission in a different way

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support.
Slide updated by Laurence Brice & Luke Smith

Workstream restoration	
Workstream Delivery	

Work stream: Serious Mental Illness (SMI) LCS

Highlights and Areas for Escalation

- ICS team engaged and links between T&F and ICS work stream established
- Baselines to be established
- Need assistance with conversations with Digital Team around automatic data extraction
- Refocus on the data and trajectory to meet the 60% standard – identify alternative commissioning options
- Delay in request to practices for Q2 data being sent due to significant technical issues with TPP, requested extension from NHSE
- Q2 returns showed issues around data collection in CWS, but also highlighted poor returns generally. Meeting to be held with Digital team and Primary Care to identify issues and resolve ready for Q3 returns
- MH commissioners to complete bids for resources to improve take up of SMI Physical Health Checks

Actions Completed since previous report

- Trajectories for achievement of targets discussed and agreed
- Meeting held with BI and Digital to agree how quarterly returns will be co-ordinated and submitted
- Communication to all practices was sent week commencing 28/09/20 advising how practices can submit their returns
- Reports and guidance sent to practices to enable them to complete quarterly returns – deadline for returns 21/10/20
- Final draft SOP circulated for comment
- BR had discussions with Cancer team about opportunities for working together, e.g. taking part in Cancer webinar, around opportunities for cervical screening, and using opportunistically to complete all 6 elements of physical health checks for SMI patients
- Q2 returns submitted
- MH ICS received SOP 20/10/20
- LMDs approved SOP 22/10/20

Milestone	Date	Status
Agreed Trajectories	09/09/20	Achieved
Agree whether SOP or similar required to assist practices with SMI PH	10/09/20	Achieved
Quarterly data collection process agreed, between Digital, Performance and Intelligence and Primary Care	~~3~~0/09/20	On track
Final SOP signed off at T&F Group	20/10/20	Off track
SOP to be signed off at MH ICS Group meeting	20/10/20	Off track
SOP issued	End of October	On track
Set date for Webinar	20/10/20	On track
Q2 data to be reviewed	30/10/20	On track
SOP to be signed off by clinical leads, then communicated to practices	30/10/20	On track
Place based webinars to take place lead by clinicians	30/11/20	On track

Sussex wide

Work stream: Atrial Fibrillation LCS harmonisation

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
Bronze Support:
Slide updated by Keith Hoare / Hollie Hughes

Work stream: Phase 3	
Workstream Delivery	

Highlights and Areas for Escalation

14/10/20 – update - To minimize risk for West Sussex patients, LCS Recovery & Restoration group agreed to move this action from Phase 3 to Phase 2 to expedite the harmonization of the LCS across Sussex

Clinical leads: James Simpkin, Pete Birtles, Sarah Pledger, Suneeta Kochhar, Alison Warren, Stephen Bellamy, Glyn Williams

Actions Completed since previous report

Primary Care interface with Urgent Care Stroke programme

- Initial T&F meeting 4th November to plan how to harmonize the AF specifications across Sussex, as agreed at the LCS R&R group, and to become a subgroup of the LCS R&R
- Timeline for LCS development agreed – launch projected for April 2021
- Clinical leads for task and finish group and project resource identified
- Progress to be reported back to the R&R group for the November meeting
- Risks to be identified and added – financial

Milestone	Date	Status
Draft business plan	31/11/20	
Agree tariffs with LMC	30/12/20	
Sign off person specification	19/01/21	
Approve funding	28/02/21	
Sign off LCS	16/03/21	
Launch LCS	01/04/21	

Sussex wide

Work stream: Prevention – Learning Disabilities

R&R Work stream: General Practice
System SRO: Peter Kottlar
Silver Lead: Sarah Henley
PMO Support: DK/CK/AC
Slide updated by : Penny Hawes / Luke Smith

Workstream Restoration	
Workstream Delivery	

Agenda Item 5
Appendix E

Highlights and Areas for Escalation

LD Screening Programme and Health Checks

- Proposal for Specialist Pharmacy services for Stopping Over Medication in People with Learning Disability (STOMP-LD) being developed which will support the medication review element of Health Checks. inter relationship with Medicines Optimisation programme
- Launch of Thumbs Up GP toolkit – included within practice comms 08/09 - Further support package still to be determined
- Planning for alternative provision
- Digital solutions for aligning registers

Executive Managing Director Peter Kottlar now overseeing work stream

Deep dive scheduled for 29th October

Carla Dow – writing comms evaluation process

Actions Completed since previous report

- Deep dive meeting with NHSE completed 29/10
- Options appraisal drafted – awaiting news on funding

Critical Path Milestones	Date	Status
Roll out of Thumbs Up GP Toolkit in General Practice	08/09/20	Achieved
Guidance for practices for LD	30/09/2020	On hold awaiting deep dive outcome
Deep dive completed	16/10/2020 29/10/2020	On track Completed
Comms evaluation process	31/10/2020	On track ?delayed

Sussex wide

Work stream: Prevention – Screening

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: DK/CK/AC
Slide updated by : Penny Hawes / Luke Smith

Workstream Restoration	
Workstream Delivery	

Highlights and Areas for Escalation

Immunisation & Screening

- Data concerning cervical screening indicates Brighton and Hove are below the national average, West and East Sussex are above the national average for ages 25 - 49. West are in line with the national average, with East and B&H below the national south England average for 50 – 64 ages. Further scope to take place.
- Childhood immunisations paused due to school closures, catch up programme scheduled for the autumn.
- Update 29/10/2020: S&I manager NHSE/I. Following the national guidance on maintaining childhood immunisations, the delivery of childhood immunisations and the close monitoring of uptake al local level is part of business as usual activities. The Screening and Imms Team is working closely with our local Child Health colleagues to monitor performance at local level across all 4 Local Authority Areas across Surrey and Sussex and issues around practices with waiting lists, access, delivery of imms during COVID – workforce issues and parental confidence are all being addressed and discussed at our programme board meetings with remedial plans in place.
- From next week move to interface project and monitor

Actions Completed since previous report

contact made with the Screening and immunisations Manager from NHSE/I (PHE SE) regarding addressing local issues affecting uptake. Request made by PHE for CCG representatives from West and B&H to attend the Imms programme Board – escalated for a representative to be nominated

Critical Path Milestones	Date	Status
Work stream documentation, risks and issues, etc. complete (LD element). Outstanding - Draft is completed, however requires further development	w/c 29/06/20	Achieved
To be completed	tbc	

Work stream: High Risk Patients

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: Carol King
Slide updated by Rachel Renshaw / Carol King/ /Kate Nicholls

Workstream Restoration	
Workstream Delivery	

Highlights and Areas for Escalation

- Currently no further update available from PHE re risk stratification tool anticipated for launch in Autumn 2020. This is a risk as it could destabilise other planning
- Plan to be discussed and agreed regarding Project closure

Escalation for decision / approval

- LCS for CEV patients (without access to private transport) to be considered for approval to launch as required , pending national guidance. Information indicates that there are presenting CEV/ CV patients attending hospital for whom a broader LCS may be required.
- Decision required regarding sharing of communications to CEV / CV patients with practices in order that any amendments to practice websites (where patients will be referred to), can be completed in advance as required. – Risk of milestone delay

Actions Completed since previous report

- Plan for Plans agreed to link with Health Watch and Community Hubs to further build on current Communication Plan and aim to ensure all CEV/ CV patients are reached
- Discussions with East Sussex adults Social Care re Shielding patient plan to inform prioritisation of patients to be contacted. Clinical View sort and role of BAME LCS sought. Feedback received raising concern about IG in relation to PID, further discussions to take place. Action agreed to contact Brighton & Hove and West Sussex Local Authorities
- Further focus for MDT working (with an initial focus on respiratory rehabilitation) as a new workstream or in scope of this workstream has been escalated now pending decision

Milestone	Date	Status
Launch Pilot 'Age Tool' (algorithm to calculate 'Covid age' and associated risk factor of patients) in clinical systems – to include webinar *Update: Pilot commenced and plan for expansion to inform if launch will be adopted locally –Clinical Lead and Workstream Lead suggests this is paused until response from IT team and meeting on 16/09/20 re other risk stratification tools*	09/10/20 Delayed – to be determined by Clinical Lead	Decision to delay for improved outcome
Support and advice for CEV/ CV patients developed and distributed. *Timescale confirmed by Communications team at follow up meeting*	22/09/20 Week commencing 26/10/20	Delayed on track for new revised date
Service mapping completed and recommendations made for consideration for service improvement	22/09/20	Achieved
Review completed regarding current progress against SOP expectations for High Risk Patients	29/09/20	Achieved
Covid Tool embedded in Primary Care Clinical systems	09/10/20 - Delayed – to be determined by Clinical Lead	Anticipate delay due to impact of other risk stratification tools. Further discussions needed considering new info from PHE / Docobo

Sussex wide

Work stream: High Risk Patients – Heart Failure

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: Carol King
Slide updated by Rachel Renshaw / Carol King/ /Kate Nicholls

Workstream Restoration	
Workstream Delivery	

Highlights and Areas for Escalation

- There are new QOF requirements re annual review for heart failure patients. This will support the launch of the new pathway.
- Webinar delayed by 2 weeks

ESCALATION

- A risk has been flagged to the group re patients being unable to access ICD de-activation during pandemic (for example for patients at end of life). The working group is escalating this patient care issue to the Oversight Group as senior management may wish to seek assurance that this will not be repeated / will not be an issue in the event of a second wave. Information shared with Alison Cannon providing assurance and highlighting remaining gaps in information

Actions Completed since previous report

- Agreement made by Clinical and Project leads to delay presentation to Medical Directors until next week (03/11/20)
- Pathway reviewed within sub-group and final alterations made. Pathway to be sent to the Design team for production of final document.
- Use of Organisation logo discussed and agreed with HOS for Primary Care - West Sussex CCG logo to be added to pathway
- Further plans regarding webinar launch made
- Kraydel Home Monitoring tool recorded as 'Lessons learnt' and slide has been updated.

Milestone	Date	Status
Geographical service mapping for the service footprint for the Heart Failure service (Acute and Community) produced and approved *Update: Mapping was produced by deadline. Additional information required by workstream.*	16/09/20 Completed 09/10/20	Achieved
Heart Failure Pathway presented to and approved by CCG Medical Directors	09/10/20 Anticipated 19/10/20 Delay to 26/10/20 delay to 03/11/20 to enable all final comments to be incorporated by design team to produce final product	Delayed
Presentation of existing LCS and shared learning facilitated via webinar to Primary care	12/10/20	Achieved
Primary to Secondary care pathway launched at second webinar	09/11/20	On track
All Actions completed, project closure *Update: Delayed in line with need to completed actions above – scope of Pathway extended*	01/09/20 Likely 16/09/20 Likely 30/10/20	Delayed

Sussex wide

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: Carol King/Anne Corkhill
Slide updated by Kate Nicholls

Workstream Restoration	
Workstream Delivery	

Work stream: High Risk Patients: COPD

Highlights and Areas for Escalation

Draft SOP produced ahead of schedule – signed off by LCS Restoration & Recovery group on 02/09/2020
Additional oversight process by Medical Directors requested by Restoration group – impact on critical path for publication of SOP – extended by one week.
T&F Group scoping for 2nd phase of work – to identify and review best practice locally & nationally; to undertake a review of all existing respiratory LCS specs; and to develop objectives for a harmonized LCS.
Community Respiratory teams advise unable to accept referrals without spirometry. Gap in service provision for newly diagnosed patients. Escalated at the LCS R&R group 14/10 and to be raised at the next community interface group

For escalation:
Sign-off needed by Medical Directors group a.s.a.p. as now a delay to publication

Actions Completed since previous report

Launch of clinical webinar due to consultant availability now resolved and back on track

T&F meeting on 13/10/20 reviewed and amended SOP to reflect issue of referrals to community respiratory teams. Also finalized plans for clinical webinar on 12/11/20

SOP agreed by Medical Directors group for sign-off

Milestone	Date	Status
Final SOP document agreed by T&F group	~~15/09/2020~~ 01/09/20	Achieved
SOP approved by LCS Restoration group	~~16/09/2020~~ 02/09/20	Achieved
SOP presented to Medical Directors	22/09/2020	Achieved
Reach agreement with community respiratory teams regarding the issue of requiring spirometry with referrals	~~02/10/2020~~	In progress
Guidance / SOP to practices published Delayed pending resolution of the above	~~25/09/2020~~ 16/10/2020	Revised date On Track
Clinical Webinar on COPD SOP	12/11/2020	On Track

Sussex wide

Work stream: Primary Care Winter Planning

R&R Workstream: Primary Care System SRO: Wendy Carberry
Silver Lead: Sarah Henley / Hannah Davies
PMO Support: Dee Kelley
Slide updated by James Morton

Workstream BAU	
Workstream Delivery	

Highlights and Areas for Escalation

- Need to confirm governance for escalation framework.
- Agree to close capacity plan.
- Hot paediatric patients agreed as a work stream for plan.
- Project support for work steams
- Need to identify support for work streams.

Actions Completed since previous report

Warning Signs and Triggers -Confirmed need to align to 'Winter and Covid-19 Command and Control and Escalation Framework 20/21. -Request for Winter Planning Task and finish Group to comment on the escalation framework and Monday 2 November: for further discussion ay next on 04/11.

Expansion of IC24 Roving GP service to East and West Sussex: -Meeting held with IC24 working up overarching business case for potential model of delivery by 02/10/20. Next version of business case with CCG for final feedback to IC24 30/11/20.

Outcomes and expectations from meeting 21 October

- UC and A&E deep dive findings to be presented at meeting to align with primary care winter planning
- SHCP winter plan to be discussed in relation to primary care

Milestone	Date	Status
Ratification of Key work streams and leads -- Warning Signs, triggers capacity planning and interface with A&E and Urgent tare agreed Care Homes and Frailty agreed as work stream to monitor update of OOH and temp placement care home LCS . Reprioritisation of Primary Care Service to discussion 21/10/20.Agreed Hot Paediatric patients to be part of this workstream.	~~09/09/20~~ ~~07/10/20~~	At risk
Warning Signs and Triggers – Aligned to 'Winter and Covid-19 Command and Control and Escalation Framework 20/21 Request for Winter Planning Task and finish Group to comment on the escalation framework and Monday 2 November: for further discussion ay next on 04/11 three categories of response as follows Actions taken within existing financial envelopes/contractual arrangement Actions taken which are not currently funded/within existing contractual arrangements Services/activities which a practice could temporarily suspend in order to release additional capacity.	~~14/10/20~~ 04/11/20	At risk
Interface with Urgent Care and A&E – Full presentation of UC and A&E deep dive and interfaces to presented on 21/10/20 to align with PC winter planning.. Feedback on discussions scheduled for 28/10/20 and updates to be provided in next slide deck.	21/10/20	At Risk
Febrile Patient Pathways : keen to have a pathway and way of managing "hot paediatric cases" as all children appear to have a temperature. initial separate meeting with to scope this work out with Clinical Lead Integrated Urgent Care Sussex and Medical Director for West Sussex CCG Initial scoping meeting scheduled for 03/11/20.	TBC	
Alignment of plan with main system plan. Main winter plan submitted to A& EDB, however Head of System Resilience has confirmed more detailed plans can be inputted in next iteration. JM to confirm timescales. CLOSE?	18/09/20	On-going On track
Project plan and timescales completed.(to inform more detailed milestones). Work streams developing and formal and draft project plan in development. Project plan pending confirmation of work streams. Still awaiting confirmation of final workstreams. Aim for final project plan to be confirmed on 04/11/20.	07/10/20 04/11/20	At risk
Outline business case to be developed to look at the potential to expand the Brighton and Hove Roving GP service across Sussex. Business case received internal feedback from CCG back to IC24 by 09/10/20. CCG comments on business case sent back to IC24 for review, next version expected from IC24 on 16/10/20. Next version of business case with CCG for final feedback to IC24 30/11/20. Need to cross reference with the Same Day Home Visiting Service.	21/10/20	On track

Sussex wide

Work stream: Primary Care Data

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: DK
Slide updated by Alex Palethorpe

Workstream Restoration	
Workstream Delivery	

Highlights and Areas for Escalation

NHSE/I team gave presentation on GP appointment data on 24th Sept. Looking for 5 practices to be part of their pilot - 4 practices now agreed to be part of their pilot.

Timeline for data collection slipped due to IT issues experienced by Digital team – findings to be shared w/c 9 November
15 practices agreed to be part of pilot

Both LMT's approved pilot and funding

- Draft comms to pilot sites updated and shared with Primary Care Senior Team for approval prior to pilot launched after 27/10
- Questionnaire updated following feedback from Group and to be sent out with comms for completion by pilots.

Pilot delayed by 2 weeks due to competing priorities within digital team –
Due to be released to all 15 practices 3/11/20(following confirmation from Digital Team ok to send out) with data to be returned by 13/11/20, analysed and findings planned to be shared w/c 30/11
Risk added re the competing priorities and deadlines within the digital team that they may not be able to support the workstream now or in the long term as the Facilitation team is not resourced to carry out this work and therefore is outside their original agreed work remit.

Actions Completed since previous report

•Draft comms to pilot sites updated and shared with Primary Care Senior Team for approval
•Digital team to share qualitative analysis with 3 practices for feedback by 27/10, if favourable intention for pilot to be launched subject to comms approval
•Telephone data collection commenced findings to be fed back at 19/11 meeting
•Questionnaire updated following feedback from Group and to be sent out with comms for completion by pilots.
•Draft position statement comms sent to all 15 practices 31/10 informing them that to expect pilot w/c 2/11
•Feedback from 2 test practices received and fed into revision of search waiting confirmation from Digital Team ok to send out
•Risk identified and added re the digital team may not be able to support the workstream now or in the long term as the Facilitation team is not resourced to carry out this work and therefore is outside their original agreed work remit.

Milestone	Date	Status
Assessment of qualitative and quantitative data currently available	02/09/20 Likely 09/10/20 5/11/20	Slipped
Engagement with PCNs and other stakeholders complete – 'Wish list' and drivers understood	09/09/20	Completed
Paper to LMT requesting support and Funding	13/10/20	Completed
Preparation communication with the pilot practices sent	29/10/20	Completed
Options Appraisal presented to LMTs. Preferred option identified.	~~w/c 16/11/20~~ w/c30/11/20	Slipped
Pilot completed		
Preferred solution implemented	November	Awaiting LMT outcome

Sussex wide

Work stream: Quality, Education and sharing of good practice

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: Dee Kelly & Anne Corkhill
Slide updated by: Amanda Sangster

Workstream Restoration	
Workstream Delivery	

Highlights and Areas for Escalation

Dates for PLT confirmed as 20th January for internal PLT and 29th April for external PLT. Draft communication ready and awaiting sign-off from senior managers.

Communication with GP Federations and IPC about clinical cover for PLT's continuing. Liaison with GP Federations about potential topic areas for non-medical and non-clinical PLT workshops ongoing.

Escalation :

Proposal to merge budgets across the CCGs still sitting with Jeremy Horgan for decision. ABC have submitted an invoice so we need a decision to know how to process the payment

Actions Completed since previous report

- External training providers have confirmed dates are available.
- GP Feds are submitting quotes for clinical cover.
- Process for specialist webinars is being developed.
- Pre-COVID training opportunities are being reviewed and prioritised for future roll out

Milestone	Date	Status
Phase 1: Recommendation process to LMT; 07/07 Submission Complete – To be resubmitted to address LMT feedback	05/08/20	Achieved
Phase 1: LMT agreement and funding streams agreed (Delayed – Achieved 05/08/20)	22/07/20	Achieved
Phase 2: Sussex wide group set up to oversee, co-ordinate and make recommendations for training activity across Sussex.	~~30/09/20~~ 13/10/20	Achieved
Phase 3 – establishing BAU (Project Closure)	31/12/20	On Track

Sussex wide

Work stream: Self-refer into services

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: Anne Corkhill
Slide updated by Andrea Hill

Workstream Tasks on Track	
Workstream Delivery	

Highlights and Areas for Escalation

- Phase 3 requirement
- Further clarification to be attained regarding the content and requirement to achieve the outcome of this work stream

• Currently patient self-referral falls within the planned care pathways, although some are commissioned by County Councils E.G. maternity services, physio (MSK), terminations, sexual health clinics, IAPT.

• Initial meeting scoped other services that could possibly be self-referral such as vasectomy, tier 3 weight management and falls that could be considered.

• We have also taken advice from NHSE and the view is that this primarily sits within a planned care approach therefore, contact has been made with the Planned Care Lead to ensure that GP practices are both aware of what services can be self-referred into and to be assured that patients have access to the relevant information needed – awaiting response from planned care team

Actions Completed since previous report

- Initial scoping meeting has taken place
- Clinical leads identified
- Risks and interdependencies identified
- Project plan underway

Milestone	Date	Status
Identify clinical lead	30/9/20	Achieved
Complete initial scoping	31/10/20	Achieved
Directorate responsibility confirmed		delayed
Project plan agreed	31/10/20	Not started
Patient comms plan agreed	30/11/20	Not started

Community Joint Working

Working in partnership across Sussex

Work stream: Care Homes

R&R Workstream: Primary Care & Community Services
System SRO: Wendy Carberry
Silver Lead: Sally Smith
PMO Support: Dee Kelly / Carol King
Slide Updated by : Sally Smith / DK / CK

Workstream Restoration	
Workstream Delivery	

Highlights and Areas for Escalation

For decision /action:

•The PCN DES requirement that PCN's have detailed arrangements with Community Providers by 30th September 2020 (detailed in Schedule 7 Network agreement) requires assurance by the CCG that actions to meet this have been fully met..

Update

•Meeting took place 22/10/20 with SCFT to stocktake / agree next steps regarding Care Home Matron Model

•Discussions regarding funding routes for Community Provider models are taking place this week as a priority

•Cross referencing of CCG Care Homes spreadsheet with SPFT commenced and amendments / additions made as required .

•Assurance required that the current reporting of 100% coverage remains accurate and mitigating actions identified as required

•Draft Schedule 7 produced by the CCG for sharing and consideration by PCN's and Community Providers to use to meet expectations

•Indicative approval / broad support from LMT for SCFT Care Home Matron Model.

•Indicative issue (s) raised by PCN regarding challenges in progressing the service specification requirement for patient re-registration to re - align to PCN / Care Homes . Plan to address through introduction of checklist / assurance tool process.

•Consideration indicated by ESHT of potential support in recruitment / employment to EHCH related ARRS roles

Actions Completed since previous report

•Checklist / Assurance tool developed and being further considered by PCN Delivery Managers re content and implementation options

•Presentation at East Sussex Care Homes Group meeting on 15/10/20 agreed actions including sharing PCN alignment with Care Homes Associations, / identified Communication mechanisms to Care Homes moving forwards

•Assurance received that all Care Homes have been notified of the process to claim free iPad via NHSX to support MDT working

•Identification of PCN's with highest number of LD Care Homes completed . Plan to convene meeting with CCG LD Clinical Lead Amy Dissanayake and Peter Birtles to explore how to progress engagement of CD's aiming to support MDT working in partnership with SPFT

•Follow up meeting regarding LD Care Homes / Dementia Care Homes with SPFT/ LA's /SCFT scheduled for beginning of November . Further discussion planned re risk stratification tool, Restore 2 and Webinar for Primary Care.

Milestone	Date	Status
EHCH Model agreed by interface group (Detailed, Costed and Funding arrangements agreed);	Presented to LMT 's on 06/10/20 and 07/10/20	In progress
Signup to EHCH LCS and resolution agreed for any gaps as determined by outcome of case for change	Supplementary Care Homes LCS drafted Indicative date for commencement 01/12/20	In progress
MDT established and co-ordinated with Community Providers to meet National requirement (including development of personalised care and support plans) Establish arrangements for the MDT to enable the development of personalised care and support plans	30/09/20	Delayed – refer to actions to address re Schedule 7 in update . CCG facilitated meetings between ESNT and PCN's to explore how MDT Model can be built on / develop further.
EHCH Model is live across all care homes	01/10/20	Delayed – please refer to update re EHCH paper going to LMT. Care Homes LCS 's continue but Community Provider Model currently not 'live'.
Approach to data sharing with care homes resolved / agreed	31/10/20	On Track
Data Sharing national requirement achieved	31/03/21	On Track

Sussex wide

Work stream:
Care Home supplementary LCS (NEW)

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: Carol King
Slide updated by TBC

Work stream Restoration / BAU	
Workstream Delivery	

Highlights and Areas for Escalation

Consolidated review of existing LCS's against DES service specification completed. This will inform the content of the Supplementary LCS.

Draft Supplementary LCS has now been produced by Clinical Lead (Peter Birtles) in consultation with LMC

Meeting with LMC scheduled to discuss / approve Supplementary LCS

Draft LCS to be discussed at next LCS Restoration Group

Actions Completed since previous report

Notice service to practices on existing care homes LCSs

Consolidated review of existing LCS's against DES service specification completed. This will inform the content of the Supplementary LCS.

Draft Supplementary LCS has now been produced by Clinical Lead (Peter Birtles) in consultation with LMC

Milestone	Date	Status
Notice served to practices on existing Care home LCS	28th August 2020	Completed
Produce draft LCS	14 September 2020	On Track
Review LCS with LMT – LCS has been drafted in liaison with LMC but final approval remains outstanding	21 September 2020	Delayed – to be discussed at LCS Restoration group week commencing 11/11/20
LCS specifications to go to PCCC for sign off, and prior to that to LCS R&R Group on 11/11/20		On track
New specifications to be approved at PCCC	25 November 2020	On track
New Care Home supplementary LCS agreed and launched to General Practice	30th November 2020	On Track
Project Closure / Move to BAU approved by Programme Oversight Group	4th December 2020	On Track

Patients Flu Vaccinations

Task & Finish Group Lead – Hugo Luck

Highlights and Areas for Escalation

>58% 65+ vaccinated as of 22/10/20
Working with PCNs to understand disparity between <65 at risk performance (Btn outlier)
Latest NHSE reminder letter to patients resulted in inappropriate additional calls to practices
Vaccinations for housebound patients with SCFT agreed – ESHT to be confirmed.

Actions Completed

- Local weekly reporting on progress now in place
- Details of arrangements for accessing further vaccine from mid November received and circulated
- Process in place to receive and respond to bids for additional funding.

Key Actions Outstanding	T&F Group	Target Date	Owner
Development of a mixed model for vaccination delivery in progress with PCNs, Community Providers and Pharmacies.	Patients	complete	Hugo Luck / Mandy Catchpole
Contractual arrangements to be developed with NHS Community Providers for housebound patient groups. (partially – ESHT to confirm)	Patients	05/10/20	Hugo Luck / Mandy Catchpole
Establish vaccination model for homeless populations.	Patients	01/11/20	Hugo Luck / Mandy Catchpole
Review of NHS Provider vaccination programme for long stay patients and pregnant women. Awaiting NHS Acute Community Providers specification.	Patients	01/11/20	Hugo Luck / Mandy Catchpole
Development of mechanisms to allocate additional National funding to support PCNs in the delivery model. (delayed due to dep. on national announcement)	Patients	complete	Hugo Luck / Mandy Catchpole

Sussex wide

Work stream: PCNs

R&R Workstream: Primary Care & Community Services
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: Dee Kelly
Slide updated by : Becky Gayler

Work stream: Restoration / BAU	
Work stream Delivery	

Highlights and Areas for Escalation

- NHSE Letter 16/10 sets our Primary Care Transformation monies including Primary Care Development Funds (£1.34m for the STP)
- Menu of ideas to be developed and circulated

Escalation

- Project Manager needed to deliver EHCH digital project – Digital unable to provide this resource
- LCS funding of Care Coordinators in the legacy HMS CCG PCNs may cease at the end of 20/21 - need a decision as to whether CCG funding of these post will continue or whether they should be transferred to the ARRS scheme. Amendments will be required to PCN baselines as originally these posts were included as SPLWs in error.
- Schedule 7 Network Agreement detailing arrangements for PCN work with community services providers drafted for consultation with CCG and Community Services Clinical Leads, to be shared with PCN CDs (This supports milestone 1 on this slide) This is with Sally Smith for comment and has not yet been shared with PCN CDs.

Actions Completed since previous report

- PCN Delivery Manager support offer refined and shared back with PCN DM, following review with senior management, prior to sharing with PCNs this week.
- PNC Intranet Pages – further meeting to agree framework, scope, content and arrangements for maintenance 30/10/20
- Draft PCCC paper giving update on PCN developments has been prepared and circulated with Heads of for input
- PCN development funding for 20/21 has been confirmed - working on revised maturity matrix with aim of getting development funds out by end of calendar year
- Investment and Impact Fund - comms being developed for PCNs – presentation to CDs weekly webinars (11th-18th November)
- PCN Dashboard developed by P&I, and shared with PCN Delivery Managers to inform development of plans with CDs and development of business cases.
- Primary Care Learning Session (30/10) on PCN DES changes, focusing on Investment and Impact Fund and PCN Development fund.

Milestone	Date	Status
PCNs have detailed the arrangements with local community services providers *Interdependency; ARRS*	30/09/20	Delayed
Supporting Early Cancer diagnosis requirements implemented *Interdependency PCN DES - Cancer*	1/10/20	In progress
PCNs have detailed arrangements with community mental health providers and community pharmacy *Interdependency; ARRS*	31/03/21	On track
All PCNs and practices offering a core digital first service *Interdependency: Digital*	31/3/21	On track
Care Home requirements to view patient records in place *Interdependency: Digital; EHCH;*	31/03/21	On track
Impact and Investment Fund introduced *Interdependency Primary Care Data*	1/10/20	Off track
Transfer of Improved Access service to PCNs under DES *Interdependency: GPFV Recovery Plan, Urgent Care and Digital*	01/04/21	On track

Sussex wide

Work stream: PCN DES – Additional Roles Reimbursement Scheme (ARRS)

R&R Workstream: General Practice
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: Anne Corkhill
Slide updated by Becky Gayler

Work stream: Restoration / BAU	
Workstream Delivery	

• Highlights and Areas for Escalation

Key achievements to date
- Evaluation and review process reduced potential unclaimed funding from £1,447k to £572k
- LMC and PCN informed of Unclaimed Funding estimates in line with DES
- PCN's informed of outcome of ARRS 19/20 Underspend Business cases

Upcoming key actions
- New guidance received and being reviewed re Nursing Associate roles – especially in relation to employment of Registered Nurses in these roles
- Local offer of support to be developed, to help PCNs with the logistics of recruitment.
- Development of MoU to support sharing of ARRS posts across and between PCNs
- Guidance re remote working of ARRS posts to alleviate accommodation shortages

For escalation
- Advice requested re governance for CCG to agree changes to ARRS PCN baseline (31/3/19) before submitting to NHSE/I

Milestone	Date	Status
PCNs submit bids for Unclaimed Funding 20/21	16/10/20	Complete
CCG inform PCNs of outcome of Unclaimed Funding Bids	24/10/20	Feedback sent
Workforce indicative planning template 21/22-23/24 submitted to CCG	31/10/20	On track
CCGs submit collated first cut PCN recruitment plans for 2021/22-23/24 to regional NHSEI	9/11/20	On track
CCGs submit collated final PCN recruitment plans for 2021/22-23/24 to regional NHSEI	30/11/20	On track

Actions Completed since previous report

- 6 ARRS bids for 20/21 unclaimed funding reviewed by evaluation panel, feedback give to PCNs re risk of cost pressures in 21/22 and emphasizing that these would need to be absorbed by the PCNs. LMT paper prepared to obtain sign off on the bids.
- Paper for LMT prepared with recommendation to renegotiate the Pharmacy Technician waiver process with LMC
- 20/21 workforce plans reviewed to check whether full year costs can be met within 21/22 projected allocations.
- NHSE advice sort re proposal to transfer funding of Care Coordinators in Horsham and Mid Sussex from CCG baseline to ARRS
- Indicative future years plans are being received and shared with PCN DMs for comment.
- Meeting with NHSE/I to review ARRS workforce plans and processes - confirmation received that PCN Development Funds should not be used to top up ARRS salary and on-costs.

Sussex wide

Work stream: PCN DES - Early Cancer

R&R Workstream: Primary Care & Community Services
System SRO: Karen Breen
Silver Lead: Sarah Henley
PMO Support: DK / CK / AC
Slide updated by Becky Gayler / Hollie Hughes

Work stream: Restoration / BAU	
Workstream Delivery	

Highlights – Areas for Escalation

- CS Cancer team exploring PKB – Patient Knows Best (Patient Held Record) to help cancer patients manage their own care pathway
- Cancer Alliance has produced a support pack for PCNs to summarise support available to practices and PCNs (working in partnership with ICS, and charities) - available on the Intranet (summary for Delivery Manager is being produced)
- Meeting with Primary Care Leads, ICS Digital and Cancer Team (8/9/20) supportive of proposal to roll-out a single digital decision support tool.
- Cancer Alliance have funding to deploy in 20/21 across all practices but need CCG decision and costings before they can make a bid for funding.
- Sussex and Surrey Cancer Alliance have developed a data pack at PCN and Practice level – this is available on the Intranet and will be developed further to encompass deprivation and Learning Disabilities.
- Primary care coding requirements to be communicated to PCNs, regarding which SNOMED codes can be used to understand how well processes are being implemented in primary care.

For Escalation

- Screening guide to be signed off by Primary Care Cancer Team and circulated via Delivery Managers when finalised

Planned work

- Webinars planned Cervical Screening (including LD and SMI), Nice Guidance 12 update and refresher.
- Cancer Alliance and ICS are linking together on engagement and inequalities.

Dependency

- *Dependency with Prevention programme and Cervical Screening*
- *Dependency with Performance and Intelligence Team – to produce updates to the Data Dashboard*

Milestone	Date	Status
Procurement decision regarding digital support tools (PCCC decision 25/11/20)	30/9/20	Delayed
Early Cancer DES implementation begins and monitoring arrangements in place	01/10/20	On Track
Implementation of decision support tools across Sussex complete	28/2/21	Not started

Actions Completed since previous report

- Paper seeking approval to proceed with single system for decision support presented to LMT (4/11 and 10/11) before going to PCOG (23/11) and then PCCC (25/11)
- Procurement of decision support system will be triggered after PCCC decision, however digital are preparing ground by selecting methodology for this.
- Liaison with Bexhill PCN (13/10/20) re use of Care Coordinator as PCN Cancer Champion – this could be a role model for other PCNs – Hollie Hughes following up on progress
- Dental cancer pilot being launched with QVH – to support more rapid diagnosis using photo and video submissions
- Updated Surrey and Sussex Cancer Alliance dashboard available on intranet
- ICS Cancer Project Manager visiting PCNs on request to discuss their action plans.

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Sussex Health and Care Partnership

Primary Care Estates Strategy

1. Introduction

1.1 The health and care service needs of our population drive our local Estates planning. Buildings play an important role in improving the quality of the patient experience, service integration and staff recruitment/retention. Within our Primary Care, a fit for purpose estate is an essential enabler to deliver high quality safe and resilient services to the population of Sussex.

The purpose of this document is to set out:

- The whole systems context for our strategic work on Primary Care estates
- A vision for our primary care estate
- The role of the CCG. our primary care providers and other partners
- The current position of our Primary Care estates
- Plans for the future Primary care Estate
- Lessons learned from our current estates developments;
- Proposed next steps.

1.2 This document forms one component of the overall emerging Sussex Primary Care Strategy and reflects our wider integration work across the system. It should be regarded as a first step on the path to an overall strategy for Sussex Estates and the Primary Care Strategy overall. It will be developed and refined further over the coming months.

1.3 The Estates Strategy will be regularly refreshed to ensure it supports the development of our Primary Care Networks, any new national guidance and policy and our move towards an Integrated care System,

2. Context/Drivers for Change

There are various imperatives driving our estates planning. These can be summarised as follows:

2.1. National Context

2.1.1 In December 2015, the Department of Health asked CCGs to start developing a strategic approach to the healthcare estate in their areas. This initiative was strengthened by the Five Year Forward View and the GP Forward View, with the latter placing a specific expectation on CCGs to develop plans for their primary care estate.

2.1.2 In addition to this, the Carter Review (2016) set out the expectation that local healthcare economies would review their local estate in order to improve space utilisation and value for money (with a focus on hospital service provision).

2.1.3 The One Public Estate programme also created a national expectation that public sector buildings should be developed as assets of the public sector overall, as partner organisations.

2.1.4 The Equalities Act 2010 is a further key driver to ensure buildings – both existing and new - are accessible for everyone.

2.1.5 The recent COVID pandemic has demonstrated the need for primary care estate to adapt rapidly to changing circumstances.

2.2. Local Strategic Context and Primary Care Strategy

2.2.1 The Sussex Health and Care Partnership (SHCP) consists of the 16 organisations who are responsible for the healthcare of the 1.7m population of Sussex to deliver this healthcare vision. The partnership includes 3 CCGs aligned to upper tier authorities, who commission primary care services from 178 GP practices. The Sussex CCGs and SHCP plans support people to stay well, manage their existing conditions and retain their independence by improving primary care access and providing more community based local care to avoid unnecessary hospital visits

2.2.2 The overall vision for primary care in Sussex focuses on the provision of locally driven integrated primary, community and social care that aims to improve population health and health outcomes while reducing avoidable illness, hospital admission and care expenditure. Health and care will increasingly, be planned in a more personalised way, to take account of neighbourhood diversity and to maintain services at or as close to home as possible, as referenced in the 2019 Sussex Estates checkpoint strategy and response to the Long term Plan.

2.2.3 The SHCP will oversee the development within primary care community care through a Collaborative Network. This will ensure that there is a strategic approach to the planning and delivery of primary and community services, engaging all partners at a Sussex scale. Local plans will developed at place within East Sussex, Brighton and Hove and West Sussex to align with the new merged CCGs and as part of the reorganisation two Heads of Estates have been appointed, to bring skills and expertise in this area which has historically had a lack of attention. This will strengthen the planning and delivery at place going forward.

2.2.4 Primary care plays a pivotal role in the NHS, being the first point of contact for the majority of the population and the entry point for the prevention and treatment of illness. However, it currently faces unprecedented pressure, due to increasing patient numbers, increasing complexity of patient needs and workforce challenges. Traditionally, primary care was defined as general practice, community pharmacy, dental and optometry services. Nowadays, the scope and delivery of primary care is much wider, incorporating appropriate self-care

interventions, mental health support, community health care teams and multidisciplinary care.

2.2.5 Primary care services can be provided though a number of forms such as the independent general practice partnerships, a health centre / health hub, federations of practices or groups of practices working together as a Primary Care Network (PCN). Recent work has focused on the establishment and development of PCNs across Sussex, in preparation for partnership with all key health and care partners across the system.

2.2.6 Under our new operating model, a greater proportion of services will be delivered in neighbourhoods close to the individual's home, shifting activity from acute to community and primary care services. This shift will be facilitated by the development of Integrated Care Partnerships (ICPs), bringing together teams from general practice, community services, social care, pharmacy and the voluntary sector to design and deliver integrated pathways of care and local services in neighbourhood-based Primary Care Networks.

2.2.7 Each neighbourhood will be supported by a number of additional staff by 2023/24 through the new GP contract. Expanded neighbourhood teams will comprise a broader range of staff including clinical pharmacists, physician associates, first contact physiotherapists, first contact community paramedics, community geriatricians, dementia workers, mental health practitioners and social prescribing link workers all requiring additional support infrastructure, including estate.

2.2.8 This means creating integrated teams – generally at the level of populations of 30,000 – 50,000 – for Out of Hospital Care (i.e. primary/community/mental health/social care and the Voluntary and Community Sector [VCS]). This is likely to be through Integrated Community hubs. In some areas, these may be physical hubs and in other parts of Sussex these may be virtual hubs. The creation of integrated community hubs will help to keep the focus of our commissioning work on community-based services and aim to minimise avoidable use of hospital services.

2.2.9 To enjoy the full benefits of technology, all our systems will need to work together and share information. This digital compatibility will help deliver more efficient care, through access to online appointments for primary care, transformation of outpatient services, and roll-out of integrated health and care records. All our estate planning will ensure that a fit for purpose estate will be technology enabled to allow for the digital services that make up modern primary care.

2.2.10 High quality, resilient and accessible general practice is essential to the delivery of responsive and integrated care. A key focus of the CCGs work programme is to continue to support general practice in tackling their core existing challenges and pressures, to create sustainable primary care and good estate provision is a key enabler in supporting this.

2.2.11 A primary care estates strategy does have to take into account that the majority of the current estate is either, owned by GP partners, or has significant lease arrangements in place. Opportunities for estate at scale will always be the

strategy, but are not always possible. Where not possible the objective will always be to improve links and signposting for services, and to facilitate more joined up / integrated care.

2.2.12 Our emerging Primary Care Networks will be key partners in the delivery of primary care and will become the planning footprint for services going forward, led by their Clinical Directors.

3. Current Primary Care Landscape

3.1. Sussex picture

3.1.1 Within the Sussex footprint, there are 178 GP practices. The practices vary in size, the smallest registered list being c 1,400 people and the largest c 25,000, and are organised into 38 Primary Care Networks, covering 100% of our population.

3.1.2 While Sussex is fairly affluent overall, there are pockets of significant social deprivation, notably along the coastal strip.

3.1.3 Over the last five years, there have been a number of practice closures and mergers as a response to retirement of partners and salaried GPs, and the introduction of general practice at scale. The Sussex Integrated Care System is facing continuing workforce challenges across primary and community services caused by well-documented workforce shortages across many professions. The GP workforce in Sussex is experiencing the same challenges, with many practices adopting a broader multidisciplinary approach to care delivery to manage patient demand by employing a range of other clinical professionals.

3.1.4 Practices in Sussex are very diverse, with some in a strong position while others are significantly more vulnerable. Vulnerability factors include workload and workforce leading to lack of resilience and poor premises – which are all interlinked.

3.1.5 In line with the national trend, we have seen a recent reduction in small and single-handed practices across Sussex. This often involves an increase in travel time for displaced patients, which disproportionately affects frail/disabled patients and those without a car; it also tends to mean that the services patients access are now increasingly delivered from larger practices in more extensive facilities, with greater resilience and a wider range and choice of services. This allows key medical staff to focus on where their skills provide most benefit.

3.1.6 Successful and thriving practices tend to teach and train medical, nursing and other students. Whilst many of our practice are training practices, the Sussex CCGs' ambition is for all practices to be involved in teaching and training in some way and each CCG is developing links with the Medical School, universities and Health Education England to help achieve this. There are opportunities for service redesign to support this, and these will need to be reflected in our estate planning.

3.1.7 In recent years, following the introduction of the General Practice Forward View and as demonstrated during the recent COVID-19 pandemic, the use of digital/phone contact for primary care consultations has been adopted and grown year on year. If this pattern continues as expected, there will be fewer attendances at surgeries and less emphasis on the need for paper-based notes to be stored in practices. This direction of travel needs to be balanced against a sustained increase in multi-morbidity/complexity of work in primary care that means that patients who do need to attend their practice in person are likely to have increasingly intense needs, involving longer appointments and accessible buildings. The impact of both of these trends will need to be reflected in our planning.

3.1.8 The current COVID-19 pandemic has required a significant change in the way primary care operates and the rapid adoption of hot sites has shown that surgeries can provide services from different types of buildings. The situation has also required a rapid move to remote consultations that both clinicians and the population have accepted. New primary care estate provision will build on any positive outcomes relating to new ways of providing patient care that have arisen during the pandemic.

3.1.9 A Primary Care data collection exercise is being undertaken by NHS England (NHSE) which is a 15 month national programme, with practices in Sussex due to be reviewed in the latter part of 2020/21. This will include a physical review of all premises, a condition survey and a gap analysis. The results of this survey will contribute to the prioritisation of primary care estate developments across Sussex and to the implementation plans in each CCG.

3.1.10 An update to the national guidance on PCN services and associated estate requirements, is expected shortly along with a refresh of the Premises Costs Directions. The Primary Care Estates Strategy will be reviewed in the light of these documents, as and when they are issued.

3.2. East Sussex

3.2.1 East Sussex has a population of c 550,000 and covers an area of 692 square miles of rural, urban and coastal communities from Rye in the east to Newhaven in the west. East Sussex is predominantly a rural area with generally poor road and rail links across the county. The majority of patients access the two main hospitals, Conquest in Hastings and Eastbourne District General Hospital for the majority of their secondary care services although patients on the edge of county also access services in Maidstone, Tunbridge Wells and Brighton.

3.2.2 The population size of both Eastbourne and Hastings is relatively stable. There are some changes in Rother and Lewes but Wealden has the highest expected increase in population. The 2018 ONS data shows that the population of East Sussex is expected to increase by 4.5% by to 586,026 by 2030, higher that the national average increase of 4% but lower that the Sussex average of 5%.

3.2.3 Mortality from causes considered avoidable is significantly lower in East Sussex than the national picture with the exception of Hastings, which is considerably

higher. The most deprived neighbourhoods in the county are all located in coastal and urban areas.

3.2.4 Within primary care, there are 61 general practices with list sizes ranging from 2,700 to 18,000, operating from 87 separate sites.

3.2.5 The primary care estate ranges from single hander practices in old Victorian style buildings to large practices in purpose built estate. The practice premises are a range of owner occupied, leased from third parties outside the NHS and some leased from NHS Property Services.

3.2.6 When considering the national guidance on space requirements per registered patient, none of the East Sussex surgeries meet the current guidance and some are significantly below this. When coupled with the anticipated housing growth, significant investment in primary care estate infrastructure will be required over the next 20 years.

3.2.7 A number of developments and expansion schemes are already underway to address this gap, as listed in Appendix 1.

3.3. Brighton and Hove

3.3.1 Brighton and Hove CCG covers a geographical area of approximately 34 square miles with a population of c294,000 and shares the same boundaries as Brighton and Hove City Council and is predominantly an urban area. The CCG currently has 35 practices operating from a total of 40 sites

3.3.2 The population of Brighton and Hove CCG is diverse. According to the 2018 ONS population projections, the resident population of the city is predicted to increase by 3% to 302,963 by 2030. This is lower than the predicted increases for England and Sussex

3.3.3 A number of development schemes are already underway to address this gap, as listed in Appendix 1.

3.4. West Sussex

3.4.1 West Sussex has a varied geographical footprint, ranging from quite dense urban areas (such as Crawley) to large rural parts with significant national trust protected land and villages on the outskirts. In line with other parts of Sussex, there is a significant coastal area and a seasonal influx of visitors. The current population is c 870,000 but the ONS 2018 data projects an increase of 5.9% to 923,647 by 2030. This is the largest increase in Sussex and higher than the national average.

3.4.2 The population of West Sussex was previously covered by three separate CCG bodies, two of which had assumed delegated commissioning powers from NHSE

while Crawley CCG remained under NHSE. From April 2020, all of West Sussex is under delegated commissioning for Primary Care and a single CCG.

3.4.3 There are 81 practices in West Sussex operating from 107 sites. Some GP practices are working from an estate that has been common since the beginning of the NHS – in that they are working from converted homes. A few practices work from modern new builds. There is a mix of GP owned estate and leased estate (usually on a long term lease of 20 years or greater).

3.4.4 A summary of the projected population changes by age group for each previous CCG area is shown below.

3.4.5 The estate size and population cover varies across the patch, as the population size and indeed urban/rural type varies. The estate was put in place to meet the needs of the population at the time it was built. A number of development schemes are already underway to address this gap, as listed in Appendix 1.

4. Future Primary Care Landscape

4.1 Over the next ten years, there will be significant housing growth across Sussex, particularly in West Sussex. This will generate increased demand on all services but particularly primary care as the first point of contact. An initial estimate of local authority housing plans shows that using a guide ratio of 2.3 occupants per dwelling (based on ONS data) there will be an increase in Sussex of c 162,000 population and therefore potential new patient registrations. This ranges from c 13,000 in Brighton and Hove to c 99,000 in West Sussex.

4.2 The resident population across the overall area is expected to increase between 2016 and 2030, from a projected range of between 9.2% increase in the Brighton & Hove and High Weald area, to a 12.0% increase across parts of West Sussex. The Over-85 group will see the largest increases, with population growth of between 32.5% and 42.1% predicted over the same period. The most significant factor contributing to the anticipated population increase is the planned housing development in each local authority area (see table 1 below)

Table 1

Planned Housing Growth between 2020/21 and 2030/31	**New dwellings**
Worthing	1,540
Hastings	2,118

Eastbourne	2,319
Adur	3,081
Chichester	3,527
Crawley	3,861
Rother	4,217
Lewes	5,061
Brighton	7,260
Horsham	10,784
Wealden	13,865
Mid Sussex	15,933
Arun	16,327

East Sussex CCG	27,580
Brighton and Hove CCG	7,260
West Sussex CCG	55,053
Sussex Total	89,893

Table 2

Estimated increase in housing population assuming 2.3 persons per dwelling

East Sussex CCG	63,434
Brighton and Hove CCG	16,698
West Sussex CCG	126,622
Sussex Total	206,754

4.3 The additional population will require expansion space in general practice premises. Most practices are unable to expand in their current locations so increased capacity is most likely to come from new build developments, linking in with PCN services and other community health and social care infrastructure. This is likely to include existing surgeries relocating to new expanded premises in order to absorb the additional patient numbers.

4.5 Under the General practice Forward View programme (GPFV), general practice is transitioning into new ways of working with the adoption of telephone and on-line consultation methods, which reduce face-to-face contacts for some aspects of care.

4.6 Based on the five year planning cycle recommended by NHSE, the impact on primary care rent reimbursements reflecting the consequences of housing growth across Sussex will reach £8m per annum by 2026.

4.6 This programme in Sussex, takes account of the training needs for both clinical and non-clinical staff and the training needs of the general population for whom this will be a new way of accessing healthcare. Any potential savings in physical space resulting from these new ways of working will need to be considered against the anticipated growth in the number of over 85s, who tend to have more complex care needs, along with the needs of patients who are unable or unwilling to make full use of new technologies.

5. Engagement with Local Authority partners

5.1 The local district and borough councils are currently consulting on their development plans. These set out the strategic framework for planning for each area - including housing development priorities (see section 4 above) and the impact of these on community services and facilities, including health. The results of this will affect the development of Section 106 and the Community Infrastructure Levy (CIL). These are legislative instruments, whereby property developers who are granted planning permission to build new houses are required to recognise the impact new developments will have on public service infrastructure and make a contribution (either in financial or space terms) to mitigate this impact. Section 106 or CIL should be the first funding source of any estate works/build, where there is housing development.

5.2 The CCG is actively engaging in this work and expecting to see the impact of housing developments on primary care as one of the areas that should qualify for consideration under Section 106/ CIL. (It should be noted, though, that this funding may help to a small extent with capital costs but does not support revenue costs associated with increased space – see Finance section below.)

5.3 In East Sussex the CCG is part of the Strategic Property Assets Collaboration in East Sussex (SPACES) which includes a wide range of public and voluntary sector partners, including all local NHS trusts. The group seeks to reduce costs by sharing property or services and to reduce the carbon footprint. Regular meetings are in place between the CCG and the five district councils and a number of opportunities for joint collaborations are actively being explored.

5.4 In Brighton and Hove a forum has been established, where key health and care estates managers from across the city come together to work on areas of key strategic concern in relation to the effectiveness of service delivery. (This forum is an adapted meeting of the pre-existing Greater Brighton Public Sector Property Operational Group Meeting.) This is beginning to prefigure the integrated commissioning arrangements that are central to our future vision.

5.5 In West Sussex, progress and understanding between Primary Care and local councils has increased in recent years with regular council and Primary Care estate meetings and responses to housing planning. Working together for the population benefit is improving every year. Housing opportunities vary amongst the councils with more urban areas having limited scope, as do some rural areas of protected land. There are some areas with large housing growth where there are very strong links between housing applications and contributions to health infrastructure. In areas with significantly higher housing volumes such as Arun,

the District Council has had a strong link with Primary Care for a number of years, In Horsham and Mid Sussex there has historically been a good link between health and local authorities.

6. Finance

6.1 Different organisations are involved in health and social care and each operates under a different funding mechanism in relation to estates. Key points to note are:

- Under co-commissioning CCGs are responsible for commissioning Primary Medical Services under national and local contracts - including the buildings for service delivery.

- CCGs cannot hold an interest in any building other than their headquarters and have not traditionally had significant expertise in property development. Any properties or leases previously health by Health Authorities were transferred to NHS Property Services (NHSPS) when CCGs were formed. NHSPS is now the landlord for some general practices and other community services and works closely with CCGs to ensure the efficient use of public sector estate.

- General practice premises funding is governed by the Premises Costs Directions (PCDs) which dictate the funding to which they are entitled and elements of the financial support to practices that CCGs are obliged to consider. Under the PCDs practices are entitled to reimbursement for the total Net Internal Area of the building they occupy to deliver primary medical services. This commitment is open-ended, so every additional square metre of space that the CCG commissions, ties up funding for the longer term in "bricks and mortar" – and newly-built space attracts a higher market value reimbursement than old space. An update to the PCDs is expected shortly

- NHS trusts hold large property portfolios and Capital Asset Registers and need to make a return under the Public Dividend Capital regulations. They have expertise and capacity for estates management.

- Councils hold significant property portfolios and have a key role to play in housing and the environment. They have significant levels of expertise and capacity for dealing with estates and the CCGs are developing a more mature relationship with our Council colleagues in regards to this. As indicated above, they hold the lead role on the levying and allocation of s106 and CIL.

6.2 Each of these agencies can play its part in creating estates solutions to meet specific circumstances and timescales. However, in order to deliver a successful estates development considerable skill, knowledge and capacity needs to be available.

6.3 Whilst the CCG has been able to preserve and increase investment in primary care, the signs are that health and social care budgets (both revenue and

capital) will continue to be constrained for some time to come, with the consequent need to consider value for money being paramount. Given that practices' entitlement to reimbursement of recurring rent, business and water rates continues throughout the length of their contract (which is open-ended in the case of GMS), any additional premises commitments need to be considered very carefully from an opportunity cost point of view. The CCG will need to satisfy itself that it is securing the maximum from existing estate before any new developments can be supported.

6.4 There is a programme of work being undertaken at national level to produce guidance on the estate requirements for PCN services and advice for commissioners on how to respond to PCN applications. It is expected that this will offer more flexibility in terms of rooms sizing going forward to reflect the diverse nature of services provided in a primary care setting, and the new ways of working such as remote consultations.

6.5 The Primary Care data collection programme is a national programme managed by NHSE to collect data on existing primary care estate including a physical review, a costed condition survey and a gap analysis. The Sussex primary care estate is due to be reviewed in the final stage of this programme expected to be in Q3 or 2020/21.There is an expectation that the outcome from this review programme will be referenced in any future business cases for primary care developments.

6.6 From a commissioning perspective, we are moving towards regarding health and social care commissioning budgets as a single resource, to be invested in achieving the maximum health and social functioning for our population.

7. Learning from Existing Projects

7.1 The three CCGs are currently working on a number of primary care estates projects. (Appendix 1). Key learning points that we have derived from these projects include recognition of the need for:

- Aligned commissioner and provider leadership and incentives – especially for GP-owned premises;
- Strong multi-agency planning, working, ownership and financial commitment that put patients at the centre, where there is a very direct conflict of interest;
- A robust project pipeline for future schemes produced by a strategic gap analysis;
- Clear and realistic expectations of all stakeholders – with providers that are demonstrably robust - before schemes start. These elements will be backed up for the future by accurate and relevant scheme Project Agreements;
- A flexible approach – one size does not fit all – especially in dealing with the complexity of mixed use premises;

- "Parent Organisation(s)" to take risk in certain areas, including holding longer term leases/head leases and providing expertise (though it should be noted that arrangements with such organisations need CCG indemnity/long term assurances on financial flow depending on the structure of the scheme);

- An owner of any estate (if a new build) identified at the earliest opportunity (PID, Project Initiation Document, stage at the latest), to drive an application. This is essential for multiple stakeholder / lease holder estate;

- Orchestrating financial flows to achieve desired outcomes;

- Managing capital/one off expenditure such as the Estates and Technology Transformation Fund (ETTF), developer capital, section 106/CIL etc;

- Managing revenue in coordination with capital – Premises Cost Directions, practice contributions, CCG contributions under S96, stranded/double running costs (e.g. leading up to the expiry of an existing lease);

- Managing complexity – aligning and organising funding flows, timescales and capacity to work in landscape of with tight timescales and varying non-NHS partner requirements.

8. Supporting New Developments

8.1 Going forward, all new primary care premises developments will be driven by the needs of practice, neighbourhood and locality populations. In this way, developments will be led by CCG and Sussex wide plans, rather than opportunistic proposals.

8.2 It is likely that future developments will be for services at scale involving either mergers or co-location of practices with other integrated and complementary services. Any proposals for new single practice or branch surgery developments would need to be able to demonstrate that there are additional benefits over and above those to be gained from an integrated hub model of provision. There will be an additional financial impact resulting from this integrated way of working over and above the estimated £8 referred to in section 4.6 above.

8.3 Where proposals are for primary care services only they will need the support of their PCN partners, and will need to demonstrate how the proposed development fits within the integrated plans for the PCN, locality and CCG as a whole.

8.4 Where proposals are for "Primary Care Plus" they will need the support of all PCN and other system partners, and a clear commitment to financial support from all parties before proceeding.

8.5 All developments will be expected to follow the CCG governance process as follows:

- Registering interest in a development proposal – this would be expected to have in principle support of PCN partners.
- Where this is for a "Primary Care Plus" development (i.e. for services in addition to general practice) it would be expected to have the support of the SHCP Estates Programme Board to ensure alignment with Sussex wide strategies and plans.
- Submission of a Project Initiation Document (PID) for approval by the CCG. This should identify the lead organisation or practice for the development
- Submission of an Outline Business case (OBC) for approval by the CCG to confirm specifications and indicative costs
- Submission of a Full Business Care (FBC) for approval by the CCG to confirm space and financial details.

8.5 The CCG Heads of Estates will advise primary care providers and other colleagues to support the preparation of business cases.

9. Next Steps

- Endorsement of the draft strategy by the SHCP Estates Programme Board (July 2020)
- Commitment to investing additional resources to deliver the strategy and the recurring revenue consequences (see 4.6 above)
- Cascade the strategy to General Practice
- Place based premises workshops to be run jointly by CCG and LMC to share strategy and governance process
- Place based operational delivery plans to be produced in conjunction with PCNs and other community partners (draft October 2020)
- Results of the NHSE data collection exercise to be incorporated into place based plans (when available)

10. Summary

10.1 The Primary Care Estates Strategy is an iterative document, driven by the needs of the population. It supports the wider health and social care response to the population needs of Sussex. Endorsement of the strategy and associated resource requirements will enable the delivery of a fit for purpose estate that can be an integral part of health care provision for the Sussex population.

10.2 Housing growth is the most significant driver in the need for increased primary care estate. It is key that the CCGs maintain close working relationships with all Sussex district and borough councils and we will be seeking to optimise section

106 and CIL contributions for our joint population requirements as a first funding source.

10.3 It is a key principle that going forward there will be a move towards collaborative premises and funding arrangements to deliver the primary care estate as part of integrated estate solutions.

Appendix 1 - Projects with PID approval

CCG	PCN	Project
East	Hastings	West St Leonards Medical Centre
East	Rural Rother	Robertsbridge
East	Hastings	Ice House Hastings
East	Victoria	Victoria Drive
East	Hastings	Ore Valley
East	Hailsham	Hailsham Medical Centre
East	Seaford	Seaford Medical Centre
East	Eastbourne East	Polegate
East	Eastbourne East	Eastbourne Park
East	Foundry	North St Quarter
East	The Havens	Newhaven
Brighton	East Central Brighton 1B	St Peters
Brighton	PCN 2	Moulsecomb Neighbourhood Hub
Brighton	PCN 2/Preston Park	Preston Barracks
West	Cissbury IC	Worthing Integrated Care Centre
West	Regis	Croft (new build)
West	Healthy Crawley	Poundhill

Appendix 2 - ONS data (2018)

		Age group					
Area	**Year**	**0-4**	**5-19**	**20-64**	**65-84**	**85+**	**All ages**
England	**202**	3,254,058	10,099,471	32,819,608	9,088,382	1,416,951	56,678,470
	202	3,112,277	10,501,944	32,996,664	9,876,090	1,573,260	58,060,235
	203	3,103,426	10,323,348	33,058,017	10,887,017	1,809,990	59,181,798
Sussex total	**202**	84,987	286,385	966,332	329,506	58,914	1,726,124
	202	81,705	294,344	973,440	359,345	63,618	1,772,452
	203	81,829	286,824	972,063	398,518	73,409	1,812,644
Brighton & Hove	**202**	13,434	47,638	193,580	33,207	6,058	293,917
	202	13,197	47,910	195,156	35,386	6,196	297,844
	203	13,430	46,747	196,342	39,740	6,704	302,963
Eastbourne, Hailsham & Seaford	**202**	9,264	31,005	99,826	44,656	8,920	193,673
	202	8,802	31,697	99,688	48,584	9,634	198,405
	203	8,755	30,747	98,678	53,519	11,119	202,819
Hastings & Rothe	**202**	8,914	29,879	100,869	43,239	7,387	190,288

r	**202**	8,471	29,973	100,606	47,325	8,168	194,543
	203	8,338	28,646	99,279	52,395	9,594	198,253
High Weald Lewes Havens	**202**	8,041	30,297	95,425	36,720	6,082	176,564
	202	7,892	30,844	95,920	39,970	6,600	181,225
	203	7,973	30,012	95,287	43,972	7,719	184,964
Coastal West Sussex	**202**	24,573	81,741	271,868	116,393	20,777	515,350
	202	23,609	85,197	275,117	126,880	22,632	533,436
	203	23,657	83,530	275,089	140,623	26,146	549,046
Crawley	**202**	7,580	22,039	68,332	13,244	2,336	113,531
	202	6,827	22,885	68,426	15,021	2,233	115,393
	203	6,619	21,813	68,539	17,070	2,370	116,411
Horsham & Mid Sussex	**202**	13,181	43,786	136,432	42,047	7,355	242,800
	202	12,908	45,838	138,527	46,179	8,155	251,606
	203	13,056	45,330	138,849	51,199	9,756	258,190

Change in population between 2020 and 2030

Number

	Age group

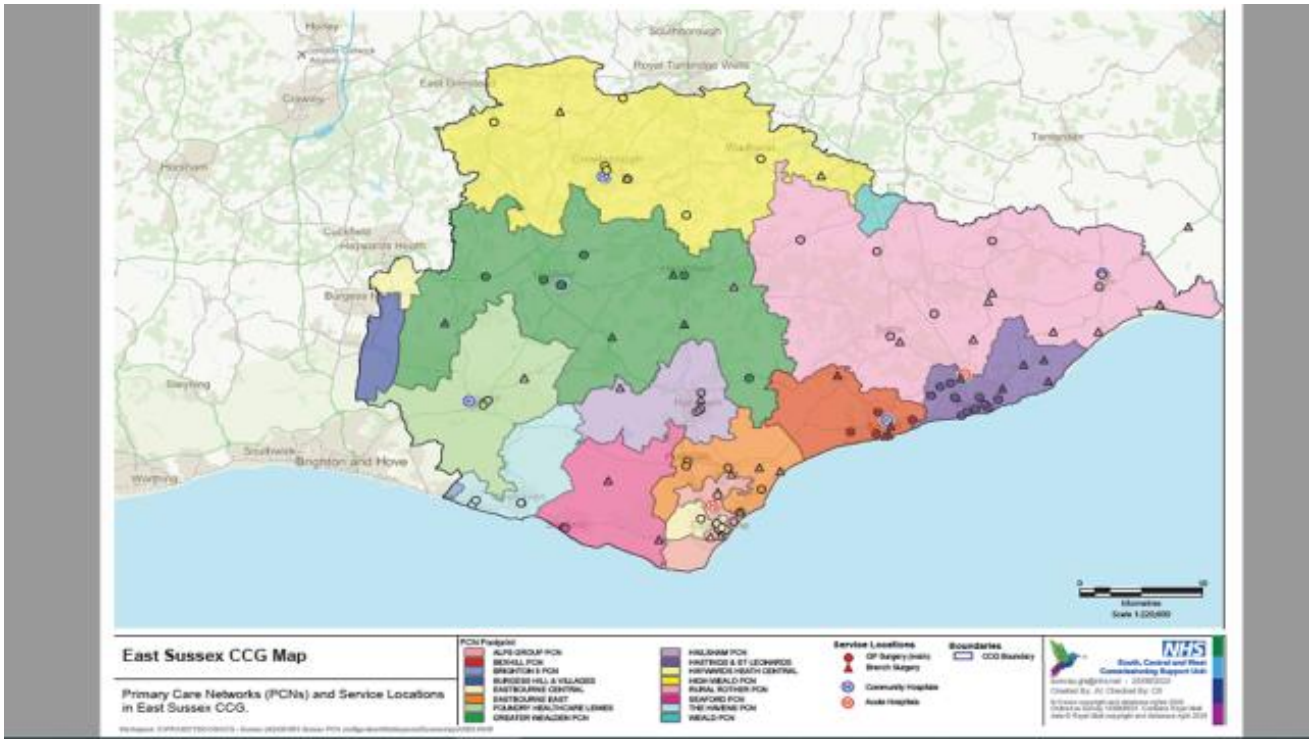
Area	0-4	5-19	20-64	65-84	85+	All ages
England	-150,632	223,877	238,409	1,798,635	393,039	2,503,328
Sussex total	-3,158	438	5,732	69,012	14,495	86,520
Brighton & Hove	-4	-892	2,762	6,533	646	9,046
Eastbourne Hailsham & Seaford	-509	-258	-1,148	8,863	2,198	9,146
Hastings & Rother	-576	-1,232	-1,590	9,156	2,207	7,964
High Weald Lewes Havens	-67	-285	-138	7,252	1,638	8,400
Coastal West Sussex	-916	1,789	3,222	24,231	5,370	33,695
Crawley	-962	-226	207	3,826	35	2,880
Horsham & Mid Sussex	-125	1,543	2,418	9,152	2,402	15,389

Change in population between 2020 and 2030

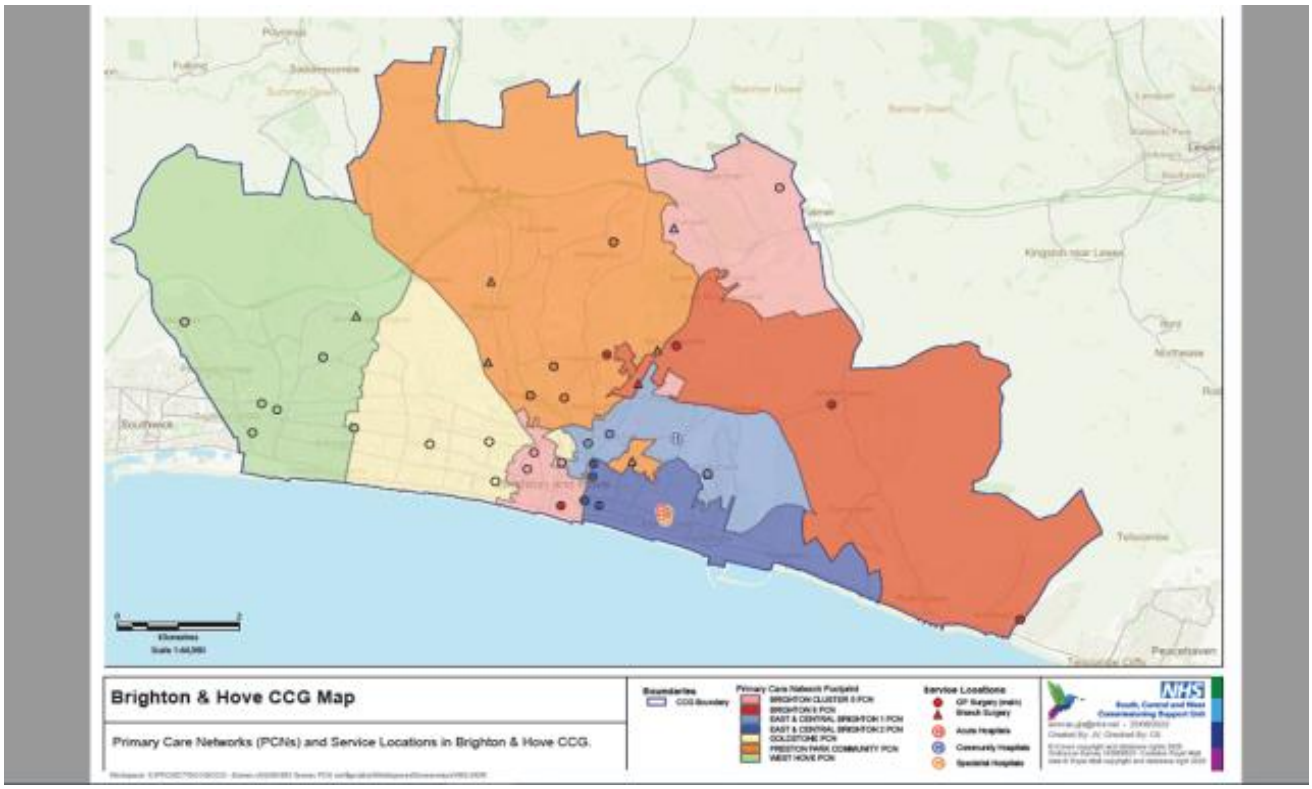
Percentage change

	Age group					
Area	**0-4**	**5-19**	**20-64**	**65-84**	**85+**	**All ages**
England	-5%	2%	1%	20%	28%	4%
Sussex total	-4%	0%	1%	21%	25%	5%
Brighton & Hove	0%	-2%	1%	20%	11%	3%
Eastbourne, Hailsham & Seaford	-5%	-1%	-1%	20%	25%	5%
Hastings & Rother	-6%	-4%	-2%	21%	30%	4%
High Weald Lewes Havens	-1%	-1%	0%	20%	27%	5%
Coastal West Sussex	-4%	2%	1%	21%	26%	7%
Crawley	-13%	-1%	0%	29%	1%	3%
Horsham & Mid Sussex	-1%	4%	2%	22%	33%	6%

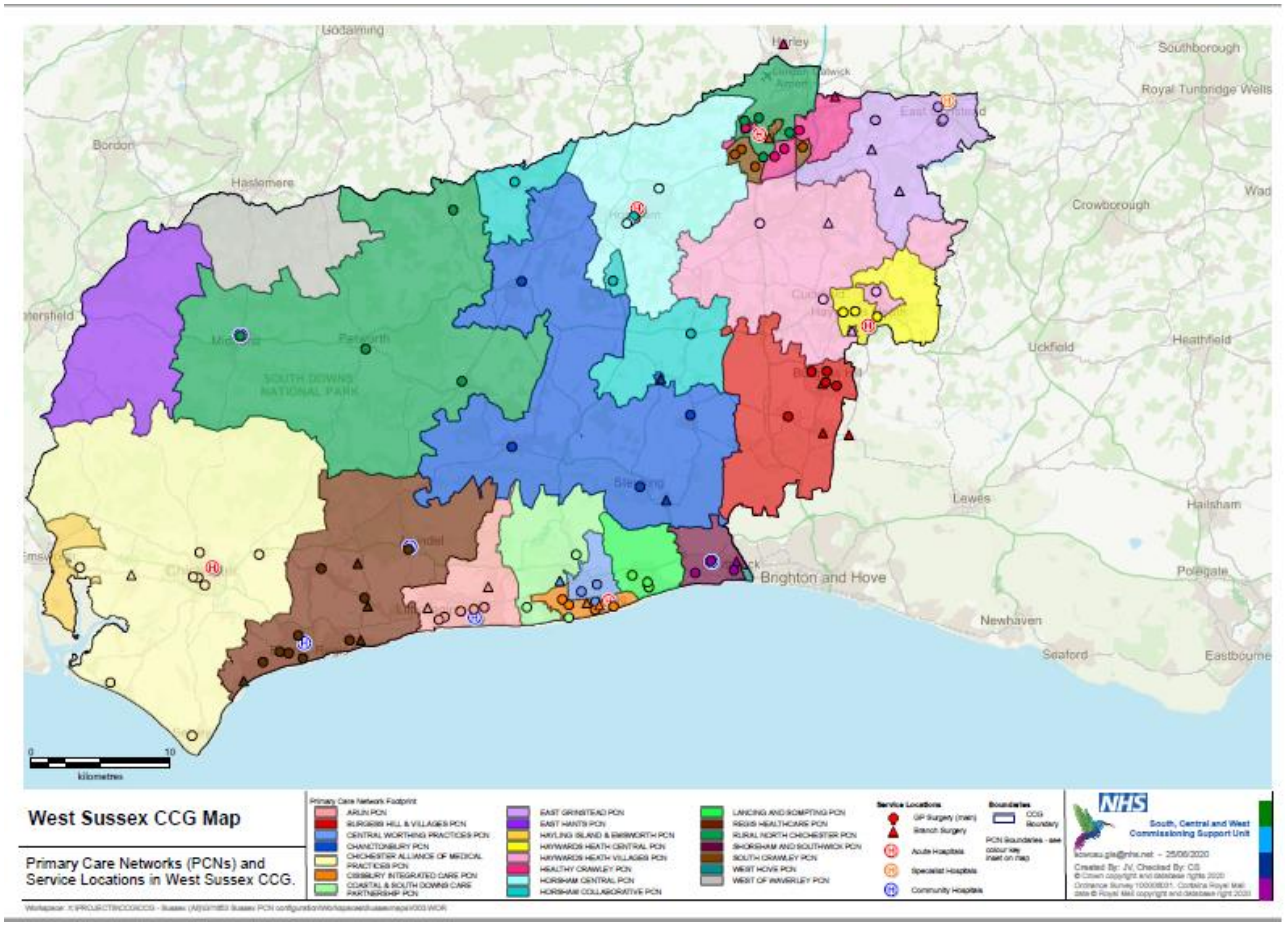
Appendix 3 - East Sussex CCG Map



Appendix 4 – Brighton and Hove CCG Map



Appendix 5 – West Sussex CCG Map



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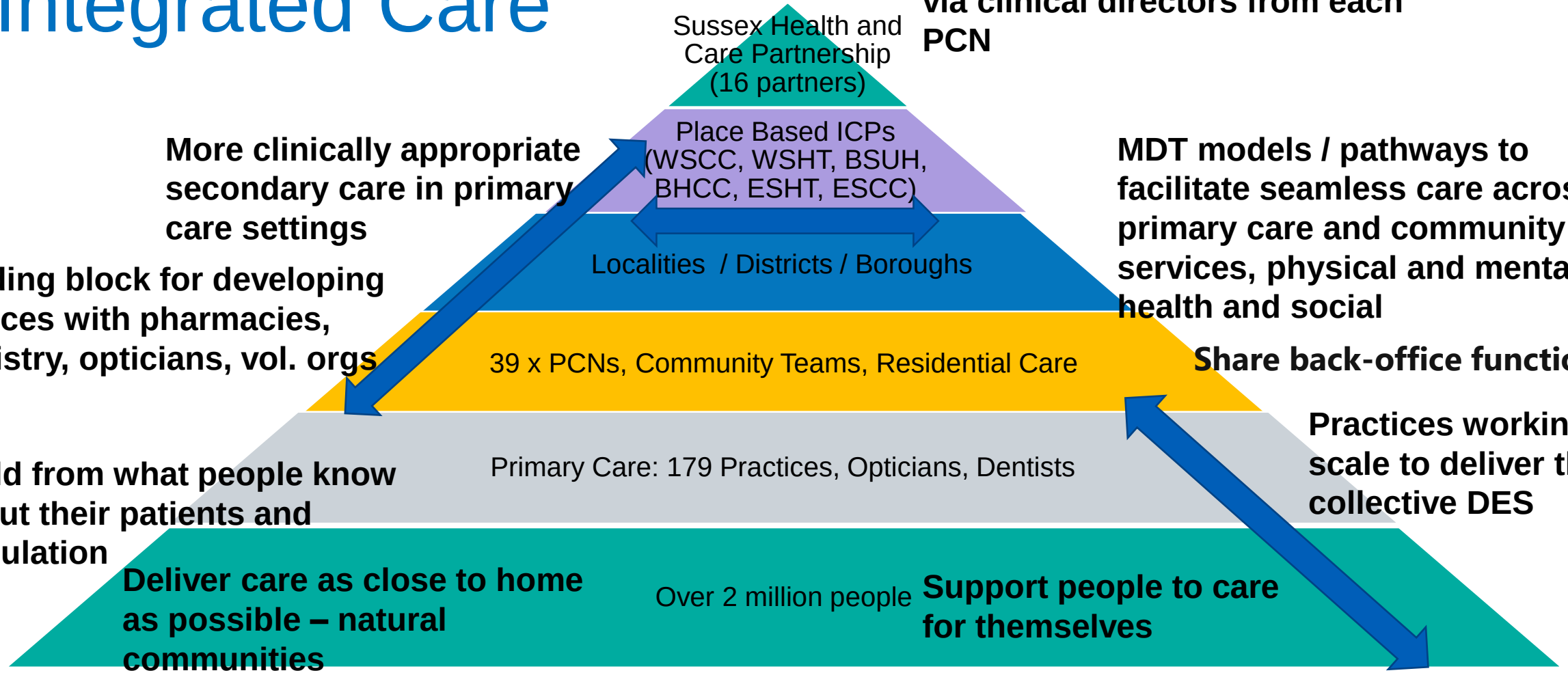
Primary Care Networks

PCNs – Building Block of Integrated Care

Primary care representation is via clinical directors from each PCN



More clinically appropriate secondary care in primary care settings

MDT models / pathways to facilitate seamless care across primary care and community services, physical and mental, health and social

Building block for developing services with pharmacies, dentistry, opticians, vol. orgs

Share back-office functions

Practices working at scale to deliver the collective DES

Build from what people know about their patients and population

Deliver care as close to home as possible – natural communities

Support people to care for themselves

Working Together

Assess population health – focusing on prevention and anticipatory health, and addressing inequalities

The Basics – part 1

- PCNs bring General Practices' together to work at scale to improve the ability of practices to:
  - recruit and retain staff
  - manage financial and estates pressures,
  - provide a wider range of services to patients more easily integrate with the wider health care system
- Size is between 30-50,000+ patients
- There are 39 PCNs across Sussex
- Geographically based
- Must cover all patients in the CCG boundary but can cross CCG boundaries
- Not mandated but practices lose extra funding if choose not to join a network and neighbouring PCN would provide network services to those patients

The Basics – Part 2

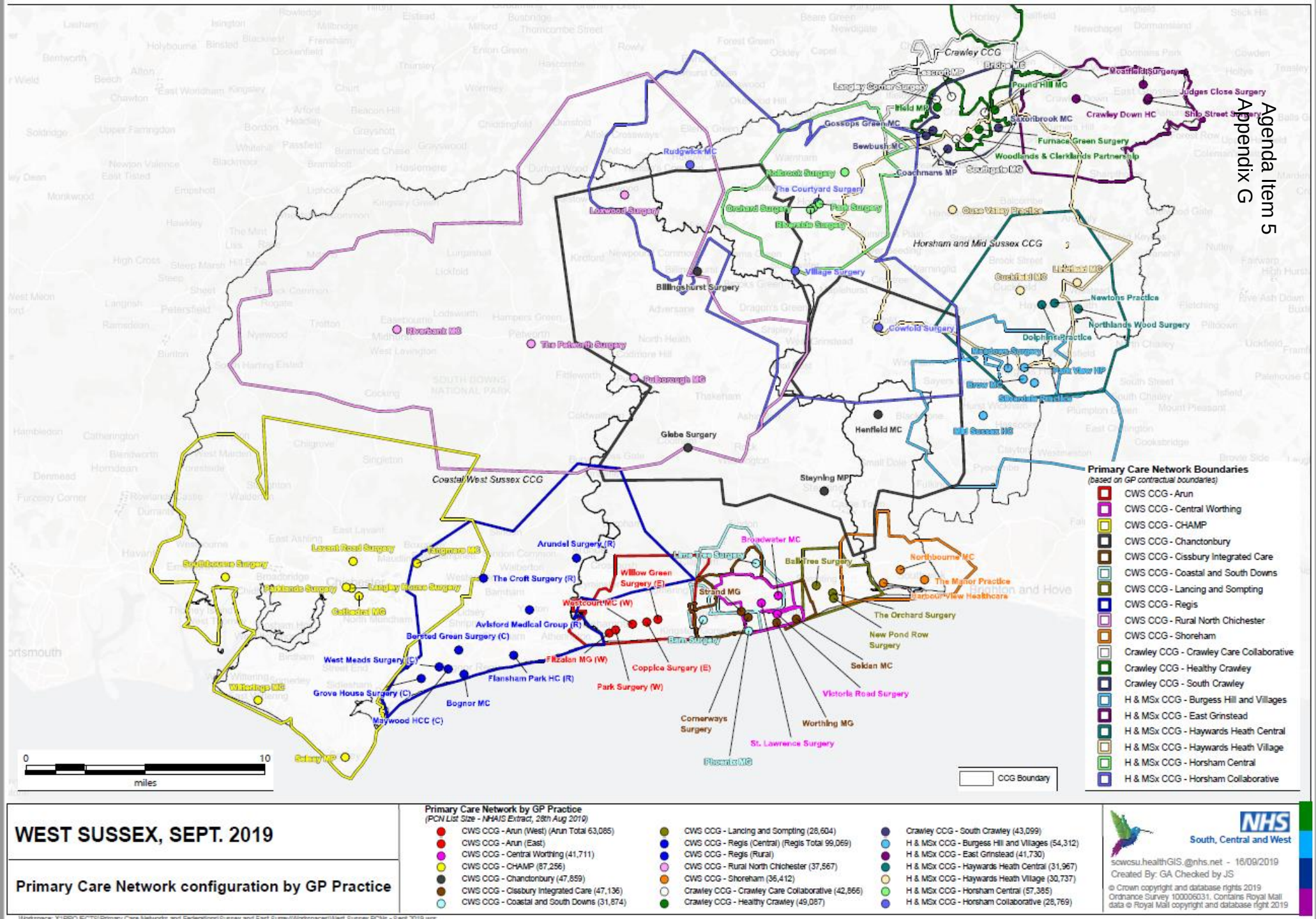
- Key vehicle for delivering Long Term Plan and a wider range of services, including national service specifications, which are currently:
    1. Extended Hours Access
    2. Structured Medication Review and Medicines Optimisation
    3. Enhanced Health in Care Homes
    4. Early Cancer Diagnosis
    5. Social Prescribing Service
- Appoint additional staff to work at scale (social prescribers, clinical pharmacists, first contact physios, physicians associates and paramedics)
- Developing integrated community based teams to provide for patients with more complex needs providing proactive and anticipatory care
- Will be focused on service delivery, commissioners will continue to commission
- Link to the Integrated Care System to represent primary care strategically

The Geography

Across Sussex there are 39 Primary Care Networks:

- Brighton and Hove 7
- East Sussex
  - Eastbourne, Hailsham and Seaford 5
  - High Weald, Lewes Haven 4
  - Hastings and Rother 3
- West Sussex
  - Coastal West Sussex 11
  - Crawley 3
  - Horsham and Mid Sussex 6

Configuration West Sussex



WEST SUSSEX, SEPT. 2019

Primary Care Network configuration by GP Practice

Primary Care Network by GP Practice
(PCN List Size - NHAIS Extract, 28th Aug 2019)

- CWS CCG - Arun (West) (Arun Total 63,085)
- CWS CCG - Arun (East)
- CWS CCG - Central Worthing (41,711)
- CWS CCG - CHAMP (87,256)
- CWS CCG - Chanctonbury (47,859)
- CWS CCG - Cissbury Integrated Care (47,136)
- CWS CCG - Coastal and South Downs (31,874)
- CWS CCG - Lancing and Sompting (26,604)
- CWS CCG - Regis (Central) (Regis Total 99,069)
- CWS CCG - Regis (Rural)
- CWS CCG - Rural North Chichester (37,567)
- CWS CCG - Shoreham (36,412)
- Crawley CCG - Crawley Care Collaborative (42,866)
- Crawley CCG - Healthy Crawley (49,087)
- Crawley CCG - South Crawley (43,099)
- H & MSx CCG - Burgess Hill and Villages (54,312)
- H & MSx CCG - East Grinstead (41,730)
- H & MSx CCG - Haywards Heath Central (31,967)
- H & MSx CCG - Haywards Heath Village (30,737)
- H & MSx CCG - Horsham Central (57,385)
- H & MSx CCG - Horsham Collaborative (28,769)

NHS South, Central and West

scwcsu.healthGIS.@nhs.net - 16/09/2019
Created By: GA Checked by JS

Working Together

PCN Development deliverables 20/21	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	21/22
DES opt-out (sign up to DES)		**29**											
Care Home Premium payments starts					**1**								
Maturity Matrix update			**To be confirmed**										
PCN / Community services arrangements agreed						**30**							
PCN / Community Mental Health and Community Pharmacy arrangements agreed												**31**	
Claim ARRS reimbursements	**Ongoing**												
Workforce planning template 20/21 submitted to CCG					**31**								
Estimate of unclaimed ARRS funding available for PCN bids						**30**							
Recruitment plans 20/21 confirmed with Clinical Directors						**30**							
Workforce indicative planning template 21/22-23/24 submitted to CCG							**31**						
Recruitment plans 22/22-23/24 confirmed with Clinical Directors								**30**					
All PCNs and practices offering a core digital first service													**1 April**

Existing PCN DES Service Specifications

Social Prescribing

- A PCN must provide a social prescribing service to their collective patients.
- GP Contract Update (Feb 20) says this service is in place to the Personalised Care spec for 20/21
- Can directly employ Social Prescribing Link Workers or sub-contract
- Personalised care and support plans
- Support people to take control of health and well-being
- Connect to community and statutory services
- Develop relationships and focus on what matters to the people and their carers / families

Extended Access

- A PCN must provide extended hours access to all registered patients
- Emergency, same day or pre-booked
- With healthcare professional or person assisting healthcare professional
- Outside practice contracted hours
- Additional to CCG Extended Access Services
- Minimum of 30 minutes per 1,000 reg. patients per week
- Face to face / phone / video
- Patients aware of service

New National Service Specifications 2020/21

Enhanced Health in Care Homes

- The aim of this service will be to enable all care homes to be supported by a consistent multi-disciplinary team of healthcare professionals, delivering proactive and reactive care. This team will be led by named GP and nurse practitioners, organised by PCNs

Supporting Early Cancer Diagnosis

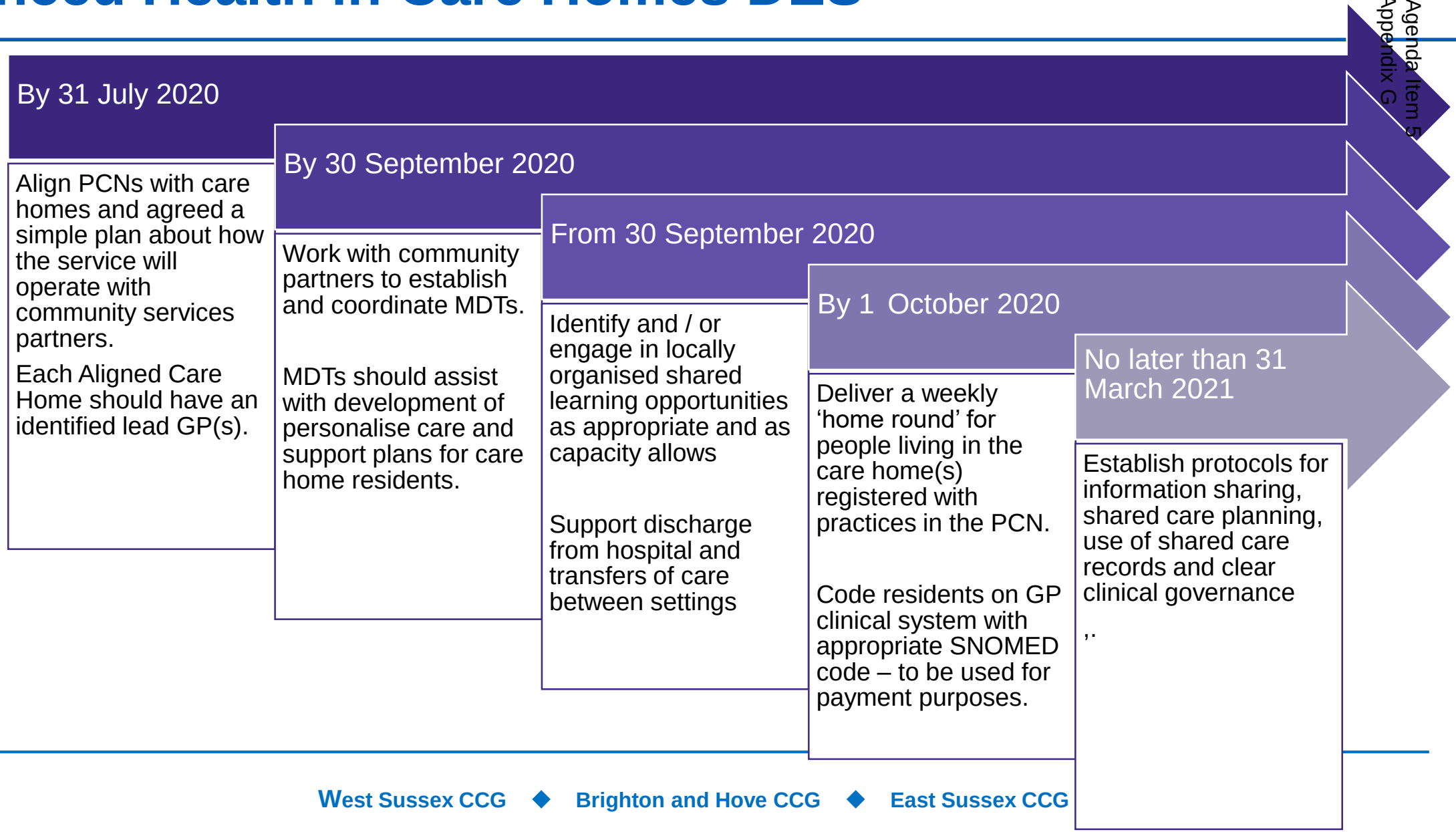
- Improving referral practice
- Increasing uptake of National Cancer Screening programmes
- Improving outcomes through reflective learning and local system partnerships

Structured Medications Reviews and Optimisation

- PCN members will support direct tackling of the over-medication of patients, including inappropriate use of antibiotics, withdrawing medicines no longer needed and support medicines optimisation more widely

Enhanced Health in Care Homes DES

Community Service Trusts are receiving additional investment under the LTP for EHCH service development



Early Cancer Diagnosis DES

From 1 October 2020 PCNs are required to:

Review referral practice for suspected cancers:

- Use clinical decision support tools
- Use practice-level data to explore local patterns
- Use the Rapid Diagnostic Centre pathway
- ensure a consistent approach to monitoring patients
- ensure that all patients are signposted to information on their referral

Contribute to improving local uptake of National Cancer Screening

- Work with local system partners to agree the PCN to improve uptake including engagement with low participation group

Establish a community of practice between practice-level clinical staff to support delivery of the requirements

- conduct peer to peer learning that look at data and trends in diagnosis across the
- engage with local system partners, including PPGs, secondarycare, Cancer, Alliance and Public Health

Work is being led by the ICS and Primary Care Cancer Leads in conjunction with the Cancer Alliance, Macmillan GPs and Cancer Research UK Facilitators

Future National Service Specifications 2021/22-22/23

- The following service specifications are to be reworked and negotiated with GPC England in a similar way to the 3 finalised for 20/21.
- In place of the Personalised Care specification, each PCN must provide access to a Social Prescribing service in 20/21

Personalised Care

Anticipatory Care

CVD Prevention and Diagnosis

Tackling Neighbourhood Inequalities