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

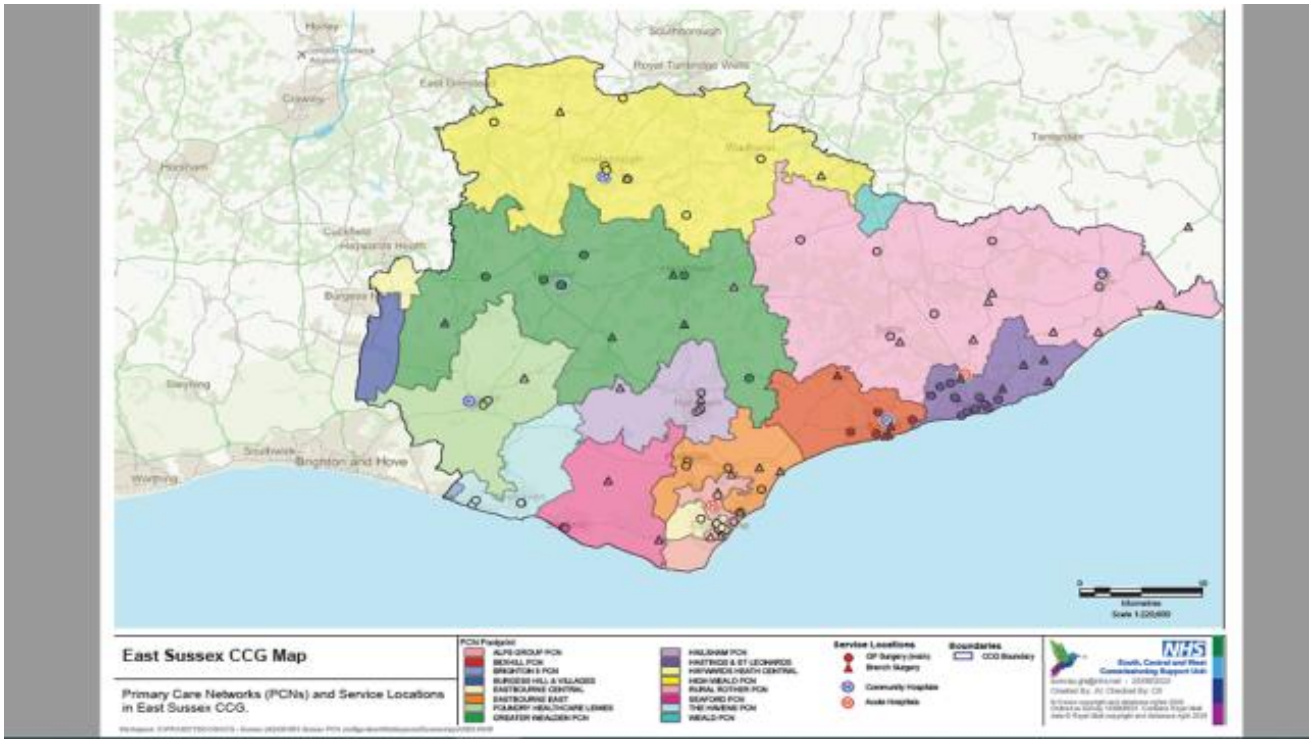
Area	0-4	5-19	20-64	65-84	85+	All ages
England	-150,632	223,877	238,409	1,798,635	393,039	2,503,328
Sussex total	-3,158	438	5,732	69,012	14,495	86,520
Brighton & Hove	-4	-892	2,762	6,533	646	9,046
Eastbourne Hailsham & Seaford	-509	-258	-1,148	8,863	2,198	9,146
Hastings & Rother	-576	-1,232	-1,590	9,156	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

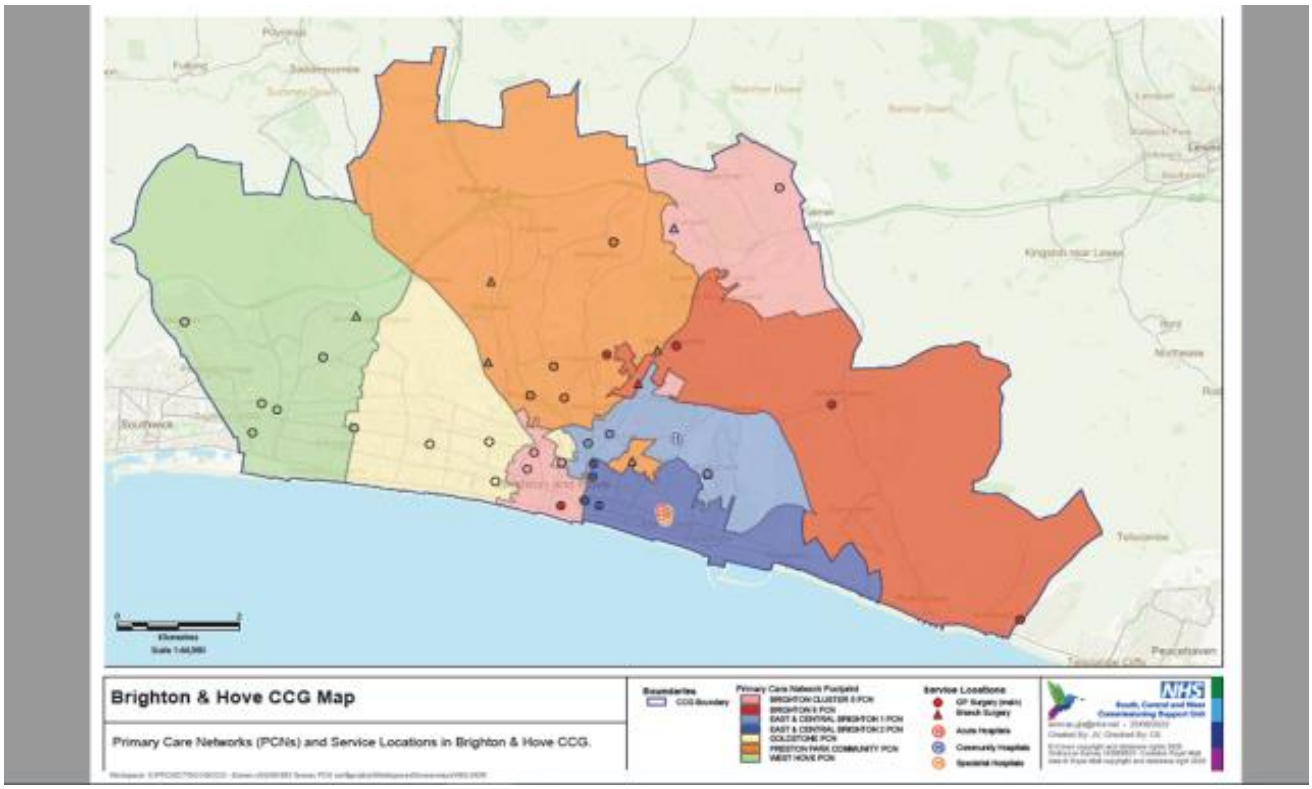
Percentage change

	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