

Phase 1: Feedback report

EXECUTIVE SUMMARY

The NHS Long-term Plan was published at the start of January and sets out the priorities and ambitions for the years ahead to ensure the NHS continues to provide high quality care for the country's population. Local NHS organisations have been asked to develop their own plans across Sustainability and Transformation Partnerships (STP) footprints.

Sussex and East Surrey (SES) STP are working collaboratively with the eight CCGs in SES to develop the local plans. To ensure consistent messages Sussex and East Surrey STP is working to engage and communicate with patients, public, staff and stakeholders. There are three key stages in the engagement process:



This report outlines the feedback gathered from the public, patients and other stakeholders during phase 1 of the engagement process (January 2019 – April 2019). The report has been structured around the ‘golden thread’ branding – Our Health and Care ... Our FUTURE – which provides a mnemonic that represents a framework for a consistent narrative.

Section 1 highlights the number of people engaged with via face-to-face conversations and the online Our Health and Care surveys.

Section 2 provides an overview of the engagement and communications methods used to engage with stakeholders, including the large-scale public events and prioritisation exercise.

Section 3 has key feedback from patients, public, carers, voluntary and community sector groups, colleagues and partner organisations.

Further feedback is detailed in Appendix 2 on:

- Prevention

- Supporting people with long term conditions
- Community and out of hospital care-integrated teams
- Mental health and wellbeing
- Maternity and children's services
- Dementia
- GP (primary) care
- Improving emergency care
- Cancer
- Digital solutions

Demographic data of stakeholders, who participated in phase 1 engagements, and their feedback, is shown in Section 3 and 4 respectively. The report concludes by explaining next steps for phase 2 of the engagement process, outlining that there will be a focus on working age people, young people, equalities groups, rural communities and areas of deprivation.



Phase 1: FULL REPORT

Section 1: Introduction

During the first half of 2019 the eight Clinical Commissioning Groups (CCGs) within Sussex and East Surrey engaged with and heard from over 850 people including members of the public, patients, partners, carers, people living with mental health, physical and sensory disabilities, people from diverse ethnic backgrounds, former members of the UK Armed Forces, voluntary and community sector organisations, partners and clinicians on their views and feedback on the NHS Long Term Plan. The conversations also included discussion relating to the Sustainability and Transformation Partnership (STP) Population Health Check document and its key messages.¹

Of the 850 people, we had face-to-face conversations with over 750 of them through a series of public events:

- 5 February in Haywards Heath,
- 6 February in Brighton,
- 13 February in Uckfield,
- 14 February in Reigate,
- 20 February in Crawley,
- 13 March in Bexhill-on-Sea,
- 15 March in Hailsham,
- 19 March in Worthing,
- 20 March in Chichester,
- 27 March in Midhurst,
- 4 April in Horsham, and
- 10 April in Hastings.

¹ Population Health Check has been developed by doctors, specialists and clinicians across Sussex and East Surrey to support the production of our local plans. A summary can be found here: <https://www.horshamandmidsussexccg.nhs.uk/get-involved/our-health-and-careour-future/#.XMlRk-hKh3g>.

Other events were also attended:

- West Sussex Health and Wellbeing Marketplace Event on 14 March;
- Healthwatch West Sussex Event on 21 March;
- REAL (Rustington, East Preston, Angmering and Littlehampton) Public Meeting on 23 March;
- BAME Health and Wellbeing Event in Brighton on 2 April.

Another 128 people also voiced their views via Our Health and Care...Our FUTURE Surveys².

We worked in partnership with Healthwatch organisations across the area to raise awareness, engage, and communicate with the public on the NHS Long Term Plan. We also modelled our local surveys on the national surveys produced by Healthwatch England. The results of the survey will be shared with local Healthwatch organisations.

Section 2: What We Did

Public events

We held engagement events in each CCG area during the day and in the evening; these events were delivered in a consistent way across Sussex and East Surrey. The events were clinically led and partners from across the STP played an active part. A PowerPoint presentation was delivered to provide an overview of the NHS Long-term plan and background information on our population. Participants were invited to join small group discussions, which were facilitated by a clinician or commissioner. Case studies, themed around the Our Health and Care...Our FUTURE branding, were used to structure conversations and feedback was recorded by a member of the Engagement Team.

Survey

To provide those unable to attend the public events with an opportunity to have their say, we produced two online surveys:

- What would you do to give people more control over their care?
- What would you do to give people better support?

² Surveys close at the end of April 2019 – data to be added after this date.

The surveys were modelled on the national surveys developed by Healthwatch England, and the results will be analysed by the Sussex and East Surrey STP and shared with Healthwatch.

Prioritisation

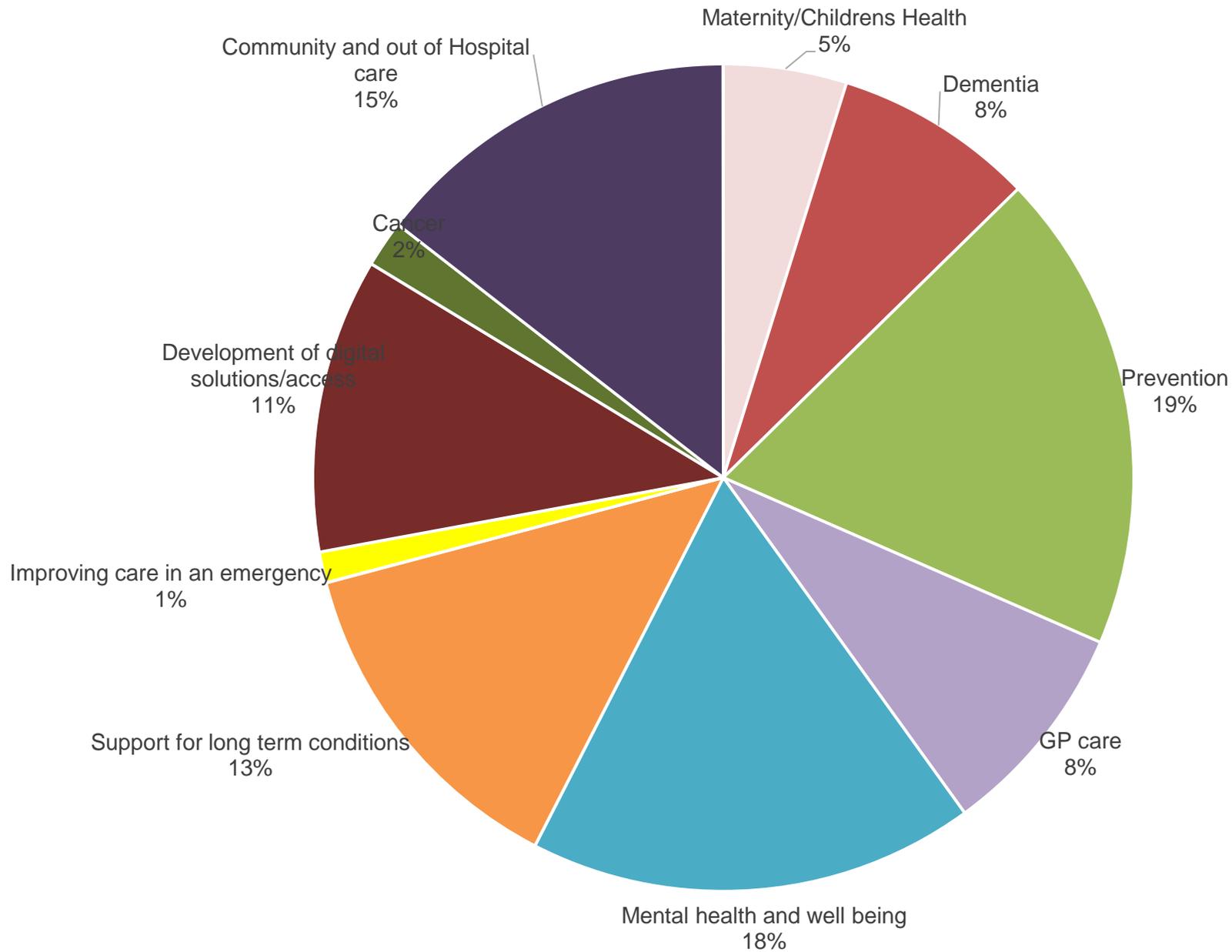
As part of the engagement process, participants were asked how they would prioritise funding, based on key areas on the Long Term Plan. The key aim of this exercise was to foster an understanding of the difficult decisions that must be taken with limited resources

- Supporting people with long term conditions
- Community and out of hospital care- integrated teams
- Mental health and wellbeing
- Maternity and children's services
- Dementia
- GP (primary) care
- Improving emergency care
- Cancer
- Digital solutions
- Prevention

The outcomes of this exercise are outlined below; note that this is indicative only, and will not be used in isolation to prioritise NHS funding or service delivery.

Figure 1: Our Health and Care...Our FUTURE – Prioritisation Data (collected at the above events)

Our Health and Care...Our FUTURE - Prioritisation Data So Far



2: What we heard from patients, public, carers, voluntary and community sector groups, colleagues and partner organisations



We said: “there are a growing number of people who need ongoing, long-term treatment for conditions and this increases the demand on services and resources. We want these people to be able to get the care they need, but to do this we need to change how we give patients treatment and care and how we use the limited resources available.”

We heard:

- There was **general acknowledgement** of the challenges faced by the NHS and Local Authorities in funding and providing health and care services.
- There was **acknowledgement of, and agreement with**, the challenges outlined in the Population Health Check document.
- Participants were in agreement that **services need to change**, but also strongly felt that the behaviours of “the public” need to change concurrently – so that people take responsibility for their health and wellbeing.
- One key challenge was felt to be **improving communication** between local health and care services and the patients and public – there is a lack of coherent, simple information, and communication.
- It was felt that patients needed **more information** explaining how the NHS system works and what they can expect – including waits for treatment and why there are delays (in appropriate formats).
- Existing **community initiatives** can support the NHS and care services and help alleviate the challenges, but this help needs to be sought, supported and accepted.



We said: “or us to be able to change services to better meet the needs of our people, we need to understand what those needs are. We want a better understanding of the needs of our population and will be doing this by speaking and listening to local people”.

We heard:

- The health and care needs of people often require support from many different services, so the public sector should **collaborate** and join up services such as housing, social care, transport, and health.
- The needs of **rural and urban communities** differ; rural communities are more likely to have issues accessing services related to transport, which is even more likely for older people and those relying on public transport.
- The needs of a **growing population**, particularly where there are new housing developments, need to be scoped and included at planning stages; as the risk of not doing so leads to more pressure on existing health services such as GPs and Dentists.
- There needs to be acknowledgement of the need for “**non-medical**” **solutions**. People felt that pressures in GP practices may lead to a focus on a medical model of care and that GPs and other professionals may be unaware of the range of services that could help and support patients for example, community groups and activities.
- **Shared decision making** between the patient, their family and or carer, and health professionals was recognised as valuable.
- More needs to be done to recognise and support **carers**, and to provide appropriate support.
- We need to ensure that we understand the needs of those with **dementia**, and ensure that we provide appropriate support and services – recognising that not everyone with dementia has the same needs or interests.
- The needs of those being **discharged** from hospital care should be an area of focus and work needs to be done to support people in **community settings** or in their homes.

- More needs to be done to support conversations around **end of life**, for both clinicians and patients and their families. It was acknowledged that there are valuable initiatives underway to help address this.
- **Mental health and wellbeing** was identified as a key issue, in both prioritisation and discussions. It was felt that there was a necessity for review of mental health services for young people and crisis services, as neither were responsive to need.
- There is a clear need for more focus on **prevention**, and this needs to start in education. Information on preventative services needs to be available in differing formats, from different sources and provided in ways and locations that are appropriate to the culture and needs of particular groups and communities.



We said: “Over recent years, health and care organisations have worked closer together to give people the care they need and this has brought tangible benefits and improvements to how people are cared for and how our staff work. This has included GPs, hospitals, mental health services, community services and social care services working together to prevent people becoming ill, making it easier for people who do get ill to get the care they need, and to make better use of resources.

We want to work like this more often and in other areas of health and care. To do this, we will need to change how services are planned and paid for, change how services are provided and use resources and technology differently”.

We heard:

- **Partnership** working between statutory, voluntary sector and private sector services and companies was felt to be key to a new approach. **Co-design** makes the best use of resources and can lead to a creative use of assets, and helps prevent duplication. Services should be developed collaboratively.
- **Integration** of health and care services was a key topic – there is a feeling that this is still not being achieved as much as it should be.
- It was felt that integration of services will be a challenge until there is successful **data and IT system integration** and sharing of records.

- **Digital technology** has the potential to transform services and care, including providing more support for self-management and resulting in a decrease in pressure on health services.
- The creation of “**Health Hubs**”, with a multidisciplinary approach in one location, was felt to be a great opportunity to transform how care is delivered, providing a holistic and person centred approach.
- **Social Prescribing** was mentioned throughout discussions as a key factor in transforming services, through supporting the best use of clinician time and expertise, and maximising the use of existing services and support in local communities.
- Health and care services need to be **innovative** – “community resilience” services need to be commissioned rather than traditional models, as this will help prevention. The community and voluntary sector can provide excellent support and should be seen and funded as a valuable part of the system.

Unjustified differences in our care



We said: “There are currently large differences in the way people are cared for and treated across our local NHS. Some of this is necessary because each patient is different and needs to be cared for as an individual with specific needs. However, some differences are difficult to justify, can sometimes be harmful for patients, and put unnecessary strain and cost on the NHS.

To help reduce unjustified differences in care, GPs, hospital doctors and other specialists are working together to look at how non-emergency treatments and procedures can be standardised and improved based on national guidelines and best practice”.

We heard:

- There was general agreement that it was **unfair** for some people to receive a “gold standard” service while others do not, and that there should not be “postcode lotteries”.
- It was strongly felt that clinical policies, treatments, procedures and waiting times should be **standardised and equitable** across the area.



We said: “We need to look at different ways to use our funding, staffing and facilities that allow us to give our people the care and treatment they need. This means we will have to increasingly prioritise where we spend our money and consider redirecting funding from services that are not cost-effective or a clinical priority to other essential services that need investment.”

We heard:

- It was generally felt that **moving investment** from hospitals and into primary care, community services and prevention will help reduce the impact of long-term health issues on the NHS.
- Challenges associated with **workforce capacity** were felt to be a priority area. It was suggested that there needed to be new and innovative methods of recruiting and retaining health professionals; including investment in training and support and attractive employment packages.
- It was acknowledged that across the area, many **premises and facilities** were inadequate and this should be tackled. It was suggested that the CCGs work closely with planning services to ensure that new facilities are of a good standard.
- There was acknowledgement of the **role of volunteers** in supporting health and care; volunteers could be key assets and could support the NHS at little additional cost (though it must be recognised that it is not a “cost free” option).
- Schemes that make good use of **existing staff resource** such as Active Signposting in GP practices and training staff in British Sign Language will help provide support with little additional investment.
- The use of **digital technology** will support good use of resources - for example through online GP consultations.
- There was a recognition of the cost to the system of “**wasted**” **appointments**, and it was suggested that there is some communication about how much this costs and the impact on the service.



We said: “We want all our populations to have the same opportunities to lead a healthy life, no matter where they live or who they are. We want to reduce health inequalities for our populations and, to do this, we need to look at how resources are used, we need to assess the impact of the decisions we make and to look at new ways in which everyone can have equal access to appropriate services.”

We heard:

- It was recognised that, despite some good work, there are still significant **health inequalities** across the area, with some communities and geographies affected more than others are.
- Access to **transport** can increase existing inequity; this can be particularly pertinent in rural localities, and in areas of deprivation.
- It was recognised that for some groups and communities, there is a need for help and support in **navigating** the health and care systems; this support should be funded in order to make understanding and access more equitable.
- **Boundaries and borders** increase inequity; the integration of services and working across a wider geography will help alleviate this.

3: Demographic Data

Attendees of the Our Health and Care...Our FUTURE public engagement events were asked to complete a demographic monitoring form. A total of 209 attendees completed the demographic form.

Findings

The main findings from the feedback are outlined below:

- 79% of responders described their ethnicity as English / Welsh / Scottish / Northern Irish / British.
- 73% of responders were female, and 25% of responders were male.
- 100% of responders identified their sex as the one assigned at birth.
- 6% of responders described their sexual orientation as Lesbian/Gay Woman, and 2% of responders described their sexual orientation as Gay Man.

- 26% of responders had a health problem or disability.
- 46% of responders were Christian.

Reflection on findings:

The above information shows that there are areas of our populations that we have not yet reached or heard from. This will be addressed in phase 2 of our engagement, where we will aim to engage with targeted groups and communities.

4: Evaluation of Our Health and Care...Our FUTURE Engagement

Attendees of events were asked questions on the value of the event in developing their understanding of the NHS Long-term plan, ability to contribute to discussions and views on the venue, content and clarity of speakers. Comment boxes were also included in the form. A total of 237 attendees completed the evaluation form.

Findings

The main findings from the feedback are outlined below:

- 95% of respondents had a better understanding of the NHS Long-term plan and what it is trying to achieve.
- 95% of respondents had a better understanding of the challenges facing the NHS and need for change.
- 81% felt that they were able to contribute and get involved in discussions.

General comments indicated positivity about the value of the events, but it was felt that presenters and facilitators did not always use clear and accessible language, with a heavy reliance on NHS acronyms.

It was felt that the events could have been advertised more widely and effectively.

Next Steps

These conversations will be continued across Sussex and East Surrey, with more focus on targeted groups and communities, and geographical areas. Phase 2 of the engagement will further explore the local issues, suggestions and opportunities for change, and build on the themes identified so far.

Areas of focus will be:

- Working age people – including NHS staff
- Young people (16+)
- Equalities groups and communities

- Neighbourhood groups (with a focus on rural communities and areas of deprivation)

Other organisations in the Sustainability Transformation Partnership, including provider organisations, will be carrying out engagement with patients and carers. This feedback will be collated and included in our final report and will also help inform developments in services as well as the development of our local plans.

We will continue to work with Healthwatch to gather as much feedback, and as many ideas and suggestions, as possible which will help shape and inform our local plans ready for submission in autumn 2019.

Appendix 1: Our Health and Care...Our FUTURE Engagement- materials

A set of communication materials were developed to support the engagement activity.

- Public-facing case for change document – The full version of the case for change was created in a public-facing engaging document. A summary version was produced with the same look and feel, which was written and presented in an easy-to-understand format.
- Narrative – A narrative was developed which could be used consistently for the communications and engagement activity across the STP.
- Resource pack – A communications resource pack was produced for partners to support the communications and engagement activity taking place. This included:
 - Summary document
 - Slide pack
 - Media release
 - Branded materials – pop-up banners and flyers
 - Social media assets
 - Briefing for stakeholders
 - Evaluation/feedback form

Appendix 2: Our Health and Care...Our FUTURE Engagement – Extended Feedback from the Engagement



There was an acknowledgment that the **key challenges** currently facing the NHS were: an ageing population, a growing population, evolving healthcare needs, such as the increase in cases of obesity and diabetes, the political landscape including the impact of Brexit, workforce challenges and limited resources. It was also accepted that the health and care needs of our population are constantly changing which creates additional challenges. There was agreement that the local health and care services needed to change and adapt to ensure the NHS continues to provide high quality care in Sussex and East Surrey.

Around the tables, there was general agreement that a significant challenge for the local health and care services was being able to successfully **communicate** with patients and the public. It was felt that although there were a number of positive developments across health and care services in Sussex and East Surrey, there was a lack of information, communication and education. It was identified that people would like to access information not just at GP practices, but also libraries, voluntary sector organisations, charities, faith centres, schools, local authority centres and local media. It was also suggested that local community members might be sources of information sharing – e.g. taxi drivers, hairdressers, café workers. It was suggested that periodic awareness raising through centrally sited “pop up” activities would be helpful.

It was recognised that the organisations within Sussex and East Surrey STP need to use a range of innovative and creative **communication and engagement methods** to inform and educate the local population.

There was an acknowledgement that increased demand for care and challenges around workforce have contributed to **long waiting times** to access health and care services, particularly for GP appointments and referral to hospitals. There was a feeling that more information should be provided to patients and the public about alternatives available, whether this means services in other areas or self-help so

people have more choice. There should be clear, timely and accessible information on the reasons for the wait; letters, emails and texts could be used, and other formats provided as needed.



There were many discussions on the importance of people taking responsibility for their own health with education on **self-care and prevention** recognised as key in supporting people to achieve this. It was felt that a combined approach of schools, health care professionals, voluntary and community sector organisations, housing, social services, transport services and local authorities working together to educate would support people to change behaviours and think about the long-term benefits of a healthy lifestyle. Investment in peer support projects and groups to support digital skills were suggested. Reducing costs for accessing health and exercises classes was proposed, particularly for young people and disabled people. However, it was felt that regardless of the efforts of “organisations”, the population also needed to do their part in maximising their own health.

Transport and access to services was recognised as a significant concern for the local population, which was understandably more evident in rural communities. Many noted that they had been unable to get to medical appointments due to the lack of transport. It was suggested that medical appointments for elderly patients should be scheduled during the day so they could use their bus passes. It was also acknowledged that it was harder to access community activities without transport to do so, therefore increasing the risk of loneliness and isolation – again more acutely for more rural communities.

In general, people felt that that patients and the public were unsure where to access health and care services, and which service was most appropriate. Although there were a number of positive initiatives across Sussex and East Surrey – such as improved GP access – the majority of the public were **unaware of the services**. It was recognised that a range of innovative and creative communication and engagement methods need to be used to inform and educate the local population.

Many conversations highlighted the need for **non-medical solutions** to “social” issues, whereby the pressures of the system in GP practices often leads to a medical model of care. Often what a person needs is a different type of support, whether this is benefits advice, housing support, and access to local activities or befriending or other kinds of support. These needs can often be met by existing

community-based services however, it was felt that GPs and others are not aware of the range of services or how to refer patients to them.

Many conversations with our local population highlighted that they had real concerns, anxieties and worries about **end of life care**. Death is seen as frightening, worrying and stressful, but it was felt that conversations between the patient, families, carers, and the medical professionals about choices, options and support would help. "Death Cafes" were raised as a method of supporting open discussions about end of life care. There was also a strong consensus that patients should be given a choice where they would like to die. People were interested in work going on across the area, including the Crawley CCG pilot project 'Planning for Your Care', aimed at improving the way patients are looked after at the end of life, and associated "SAGE & THYME" training for GPs, aimed at supporting health professionals to have sensitive conversations about death, and the ReSPECT project which will be rolled out during 2019.

Mental health and wellbeing services were raised as areas requiring significant attention, particularly young people's mental health. It was highlighted that services were underfunded, lacked out of hours provision, and had long waiting times, particularly in Children and Adolescent Mental Health Services (CAMHS). The lack of crisis care was also raised.

It was felt that more focus should be on **early intervention** in mental health; mindfulness in schools, mental health awareness campaigns, resilience building, social prescribing and better partnership approaches between health, social care, local authorities, schools and voluntary community organisations would support this.

Many commented on the value of **shared decision making** between the patient, their family and/or carer, and health professionals. It was felt that this dialogue would allow for shared understanding of what is appropriate for the patient, and would result in better clinical outcomes.

It was felt that the health needs of the local population residing in **urban and rural environments** were different. Isolation was reported to be a significant challenge in rural villages, although evidence has highlighted that this is also an issue in urban areas. Access to services was raised as a challenge for rural communities, including community midwives and sexual health services. There was a general agreement that the long-term plan needed to take into account variances between rural and urban communities, including their differing needs and priorities

The building of **new houses** continues across Sussex and East Surrey, which was resulting in increased pressure on NHS services. There was a particular influx of housing in Crawley, Horsham, Hailsham, Adur, Worthing and Arun. It was recognised that there was a lack and, in some areas, absence of GP or dental

practices which was causing additional pressures. NHS facilities and infrastructure need to be considered prior to the building of new houses. There was strong agreement on the importance of Sussex and East Surrey STP working more closely with local authority planners to ensure that new developments have the necessary infrastructure without burdening the already over-stretched existing services.

A number of **GP practices** were closing and merging. There were many concerns about how these patients would continue to access primary care.

Patients with **multiple complex health needs** struggle to manage their care, many of whom are housebound. There was a recognition that more needs to be done to explore methods of supporting these patients. Day centres and community transport need to continue to be financially supported to ensure these patients can access care and engage in society.

There was a lot of discussion about **Dementia and Alzheimer's**. There was a feeling that people with Dementia and Alzheimer's should be included more in mainstream community activities. In a Dementia Friendly community, the need for specialised groups would be minimal and people with Dementia could continue their individual interests for much longer. It was recognised that not everyone with Dementia has the same common interests.

It was recognised that many of our population are **carers** (in this context meaning family and informal carers), providing vital care and support that clearly saves statutory services' money. It was felt that more needed to be done to recognise and support carers. Carer recognition and identification is key to enabling the correct support for carers and those cared for. GP reception staff and collaboration with Patient Participation Groups (PPGs) were suggested as valuable assets in identifying and signposting Carers.

It was felt that there was a lack of understanding on the **Primary Care Networks** in the community. There was general agreement that more needed to be done to raise awareness of this.



It was strongly felt that health and care services needed to work in a more joined up **integrated way**; all sectors should work together to achieve this, including health, social care, education, local authorities and the voluntary and community sector. Services should be holistic, not in silos, considering the patient as a whole person.

The Sussex and East Surrey STP needs to work collaboratively towards this integrated approach.

There was a great deal of general discussion on the gap around **data integration and IT systems** between organisations. It was felt the integration of care would be a challenge until data and personal records could be easily shared between health and care services and across geographical borders.

Digital technology was recognised as a key driver in transforming services – including improving remote access to clinicians and remote monitoring of medical conditions that would support self-management and decrease unnecessary visits to primary or secondary care. NHS Apps that manage appointments in primary and planned care and guides on self-care were also suggested. It was noted that there was a danger that the digital approach could exclude some members of the population and may feel less personal; however, there was general support if it is used appropriately and where people could still see a clinician in person when needed. There was general agreement that technology should be accessible, easy to use, and intuitive. It needed to be shaped for and with the local population.

Social Prescribing was mentioned in some form in all our events; the emphasis on developing social prescribing was very much welcomed, both as a way of supporting the best use of clinician time and expertise, and maximising the use of existing services and assets in local communities and enabling prevention of health problems. Many people commented how hard it would be to know all the groups, communities, etc. “out there”. It was recognised that a physical directory would be out of date very quickly, but having social prescribers with local knowledge would help people access the right support. There was a feeling that Social Prescribing needs to be adequately resourced and consistent across all areas in terms of the level of delivery.

The value of developing “**Health Hubs**” was a key topic; it was felt that the opportunity for patients to be triaged and signposted to the relevant primary and planned care services, or voluntary and community sector organisations was positive. GPs, Pharmacists, Paramedics, Advanced Health Practitioners, Social Prescribing Advisors, Nurses, Dieticians, Health and Wellbeing Advisors and Physiotherapists should all be available in this one location. There was general agreement that this would transform primary care services, and would provide an effective use of premises and staff resources. It was also suggested that community services could provide drop in advice at the hub, therefore showing a true holistic approach to care and support.

The value of **partnership working** was raised, particularly with public health, local authorities, social services, private care companies, community hospitals, care homes, housing, and providers. We heard that most people believe that the co-

designing and co-commissioning of services makes best use of limited resources, ensures logical and strategic fit and prevents duplication.

There was a general feeling that health and care services needed to be innovative in **commissioning services**, and avoiding traditional approaches. Whilst commissioners need to follow NHS commissioning guidelines, they need to consider the value of commissioning community resilience services rather than commissioning “traditional” organisations to deliver a service. Prevention is a key area in the Long Term Plan, and it is important that innovative approaches to prevention need to be developed, which include the local community members and existing VCS organisations as resources.

The **discharge service** from hospital was recognised as a key priority. There was general agreement that the process needed reviewing, as a number of patients remained in hospital due to a lack of bed facilities in community hospitals or care homes.



In discussions on the variation of clinical policies, higher thresholds for care and criteria for treatments, there was general agreement that it was unfair for some members of the population to receive a gold standard, whilst other members of the population did not. It was agreed that there should not be a “**postcode lottery**”.

There was also a suggestion that **waiting times** for accessing health and care should be equitable – examples cited included breast screening services for women, frailty related issues, cardiovascular, hearing assessments, MSK, prescriptions for low visual aids and the availability of eye appointments. It was strongly felt that clinical policies, treatments, procedures and waiting times should be standardised and equitable across the patch.



Challenges associated with **workforce capacity** were felt to be a priority. The retention and recruitment of GPs, Advanced Health Practitioner and Nurses was recognised as particularly poor. Investment in health apprenticeships, ensuring pay scales are consistent, recruiting abroad, voluntary roles for health and care students, ‘Give back time’ guaranteed 6 month placement post qualifying, petitioning the

government to re-introduce bursaries for Nurses and providing an attractive employment package would support this. Across the STP area, there need to be new and innovative methods of recruiting and retaining health professionals and demonstrating the benefits of working for the NHS.

Premises and facilities were raised as issues requiring significant attention. There was a general feeling around the tables that the NHS facilities in Sussex and East Surrey were inadequate. Many buildings had little space and the leases were due to expire. There was also a lack of transport to access the facilities. There was strong agreement on the importance of Sussex and East Surrey STP working more closely with the local population and planners to ensure that facilities are fit for purpose.

Many noted that **voluntary roles** in health and care settings had been proven to be incredibly beneficially nationally and locally, assisting with health and care on the ground. GP Surgeries in East Surrey had developed voluntary roles as part of the Altogether Better Project, where volunteers play a crucial role in finding new ways of working together and making life better for everyone (e.g. handing out leaflets at flu-clinics, coffee mornings, outdoor exercise, books clubs and IT support classes). It was felt that across the area, existing voluntary and community sector organisations, and community schemes such as neighbourhood buddy schemes, Duke of Edinburgh, Health Champions, Faith groups, community and neighbourhood groups and Patient Participation Groups (PPGs) could be key assets and could support the NHS at little additional cost. There was a general consensus of the value of volunteer roles, and the importance of nurturing and supporting them.

Projects to **upskill GP receptionists** to signpost patients to appropriate services were thought of as positive, and recognised as supporting an easing of pressures on clinicians. There was also a feeling that training in languages, including deaf and hard of hearing training, would be beneficial. People felt that this should be rolled out across the area.

Many conversations included thoughts about the value of **digital technologies** in alleviating the pressures on limited resources as well as providing a flexible service for our constantly changing population, such as GP appointments online or via FaceTime or similar app.

Around the tables, there was general agreement on the value of **redirecting finances** spent in the acute hospital trusts back into primary care and prevention to reduce the impact of long-term conditions and illnesses on the NHS.

There was a considerable amount of support for the work of the **voluntary and community sector (VCS)** and many highlighted the invaluable work that these organisations provide. Many felt that the local voluntary services had a better understanding of the needs of our communities than the statutory sector. There was

a feeling that statutory services are very knowledgeable but they do not have the time or reach to the local communities that VCS organisations may have. There was a recognition that health and care services need to work together with the VCS; health services need to know about what the VCS offers so that they can refer to them. Voluntary community organisations need to be funded appropriately to support the health and care services.

There was a recognition that wasted appointments and repeatedly cancelled appointments were a significant drain on NHS resources. A system to track patients who had repeatedly cancelled appointments and identify the reasons for cancelled appointments was suggested. Patients who repeatedly cancel appointments should be educated on the resource and cost implications of this. There was also a proposal to introduce a system to reallocate appointments that had been cancelled.



Whilst Sussex and East Surrey STP have worked hard to address **health inequalities**, they are still prevalent across the area. It was felt that that Black, Asian and Minority Ethnic (BAME) communities, refugees and migrants, the homeless and people living in poverty and deprivation are the worst affected by health inequalities. There was an acceptance that experiences of deprivation contribute to higher rates of long-term illness, disabilities, cancer, lung disease and heart problems. Hastings, Littlehampton, Brighton and Hove, and Eastbourne are areas ranked as most deprived in Sussex and East Surrey. It was felt that more needed to be done to address health inequalities.

Access to transport was raised as a barrier to equity of access and care. There was a recognition that many specialist treatments were provided in London, such as cancer treatments at the Royal Marsden Hospital and therefore a barrier to accessing care. There was a suggestion to provide transport to patients who meet a means test. Claiming for expenses was also proposed as an alternative, at an agreed rate. As mentioned previously, it was felt that rural areas have inequity of access to services due to transport issues, and often there is less choice of services – for example, GP practices.

It was felt that some people are able to look after their health but others are more **vulnerable**, having to navigate a housing and benefits system, as well as health and social care systems with decreasing support available. We should focus spending on those who struggle or areas that are identified as more deprived and respond sooner.

There was a lot of general discussion on the negative impact **boundaries and borders** had on health inequalities. It was felt that health and care services could work closely with local authorities to reduce the effect of this on health inequalities.

Around the tables at the public events for the Clinical Commissioning Groups (CCGs) in **West Sussex**, many commented that having three Clinical Commissioning Groups in the county made little sense and complicated matters. It was felt that it made more sense for the CCGs to merge and more closely align itself with the local authority boundaries.