Clinical Care Strategy

2014-2019

Excellent care at the heart of the community
# Contents

of our clinical care strategy

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Executive Summary

Introduction
Our clinical care strategy 2014-2019 has been refreshed in line with national policy to reflect the demands of a growing elderly frail population, increasing complexity of multiple medical conditions and a rise in the numbers of school children. This is set against a backdrop of limited resources to deliver excellent health and social care. We have a fresh approach to delivering excellent care at the heart of the community and this strategy sets out how we will do this.

About the Trust
Sussex Community NHS Trust (SCT) became an NHS Trust in October 2010 and is planning to achieve Foundation Trust status. We aim to meet the diverse needs of our population of nearly 1.2 million people. We have over 4,600 staff and we are one of the largest community NHS trusts in the country. We have a unique ability to embrace care within homes and communities and this places us in a strong position to improve wellbeing and work with our people, their carers, other providers and commissioners to develop innovative and responsive services that truly meet the health and social care needs of our local population and beyond.

What we stand for
Our vision is to deliver ‘Excellent Care at the Heart of the Community’. To deliver this vision we have three strategic goals:

- We will provide excellent care every time to reinforce wellbeing and independence
- Working with our partners we will personalise services for the individual
- We will be a strong sustainable business, grounded in our communities and led by excellent staff

We value working together; achieving ambitions; delivering excellent care and we will be compassionate and caring.

Clinical Pathway Design
We work side by side with primary care colleagues (GPs, practice nurses, optometrists, dentists and pharmacists) to ensure that people are seen, assessed, investigated, treated, signposted/referred and cared for at the right time, in the right place by the right people. To deliver this care in the most appropriate timeframe we have categorised our care into urgent response, planned short term care and long term care. This enables us to shape our care around the individual needs of each person.
Clinical Delivery – our operating model
SCT has the advantage of caring for a diverse population of individual communities, each with different needs. We will deliver our care in ‘communities of practice’, where the needs of that community are considered and the services are moulded around the community in partnership with charitable organisations, community groups and other health and social care providers.

Quality
Quality is central to the care we deliver. The core of our strategy is to provide excellent care, delivered by experienced and trained staff. We aim to be a leader of quality health and care in the community and a leader of quality in multidisciplinary team working.

Our working practices are geared to ensure that patient safety, quality assurance and quality improvement are central to all we do. We achieve this through audit, research and assessment of performance and through supporting and developing our staff.
Transformation
In order to provide excellent care at the heart of the community, the necessary resources and infrastructure needs to be in place. Our IT, information, estate, people and processes will need to be set up ready to support the clinical services in five years’ time. This in turn requires planning that matches the journey we will be taking in clinical care delivery and, at the same time, we are making these changes in a challenging financial and commercial environment.

Long Term Financial Model (LTFM)
SCT has a strong history of delivering on its financial targets and we have a robust plan for financial sustainability into the future. The key to our success is delivering high quality care in a cost effective way. Our LTFM sets out how we will continue to deliver care in a sustainable way.

Success
Success of our strategy is best described in terms of how people will feel about the care they receive at the end of the five years. We describe what success looks like for the Suscombe family who reside within our Trust. This provides a glimpse into how care will be easy to access, ‘joined-together’, with one point of contact to one care coordinator who knows you and the local community well. Care will be delivered in a coordinated way involving the person from the beginning and ensuring that the needs of people in each community are met.
Introduction

Our clinical care strategy sets out how we plan to deliver excellent care at the heart of the community from 2014 - 2019. We have refreshed our strategy following the announcement of changes to the way health and social care is to be delivered in England in the Five Year Forward View (http://www.england.nhs.uk/2014/08/15/5yfv/) and in response to our patients and people. We have achieved great things in the first year of the strategy and this document sets out our refreshed plans for the remaining 4 years of the 5 year strategy.

The way that health and social care is delivered cannot stay the same. Population numbers are increasing and people are living longer, leading to more frail elderly people with multiple health and social care needs. Society and cultural evolution has led to people no longer living with, or close, to their family, and people no longer wish to or need to have their healthcare needs met by large hospitals. People’s expectations of receiving comprehensive health and social care at, or close to, their home require us to think differently. This is set against a backdrop of prudent spending on health and social care which means we have to consider how we spend every pound.

In the first year of our strategy we described our philosophy of proactive care and how this was being delivered in the first instance by our proactive care teams. Proactive care already uses the concept of population or list based care; in which we segment patients into risk groups and develop unique care goals with each patient to manage their health and care risks. There are a number of key components to the existing model which form the core of proactive care which are central to the success of list based care:

- Segmentation of patients based upon assessment of risk (hard and soft intelligence)
- Distinct and individual goal setting
- One on one relationship with a care manager or co-ordinator
- Proactive focus on prevention of deterioration and increasing risk
Multiskilled professionals working together to respond to the person’s needs (regardless of the organisation they work for)

Diagram 1:

Diagram 1 shows that by assessing the risk of health deterioration in our communities we can focus on delivering the right care for everybody’s needs. People at high risk of ill health e.g. frail elderly with multiple problems need comprehensive health and social care centred around their multiple needs. Those people with long term health conditions, some of which are hard to control, need focused efforts to prevent them needing to be admitted to hospital and enabling them to live safely at home. The vast majority of our communities who are healthy will need advice, education and support to ensure they remain healthy and stay fit.

We are focusing on delivering health and social care to local populations, where the care is tailored to the needs of the people in those towns and cities. We have set our targets based on providing care that improves the health of those areas. We have the benefit of providing care to very diverse populations, from the relatively affluent cities like Chichester, to the large areas of rural villages and towns of Sussex where pockets of deprivation are well hidden. This provides us with a challenge and an opportunity to deliver care that is really focused on the population that we serve in these areas. We will measure ourselves on how well we achieve excellent care by looking for improvements in the outcomes for populations of people in each of our localities.

As a large, geographically spread community health care provider we have the benefit of being able to develop a workforce that is well trained and has consistently high standards of care. At a time when there are fewer health and social care professional staff available
to apply for vacant posts we are developing partnerships with local universities and reviewing our working styles and conditions so that we become the employer of choice. Where we focus on providing specific care needs to local populations, it will be important to ensure a consistency of quality care standards across the geographical spread of our towns.

Patrick told us that his wife Sylvia had received good care from the community and palliative care nurses as she approached the end of her life due to a terminal illness but that on occasion the community nurses did not turn up on time; and sometimes information about Sylvia’s care was not passed on to other agencies. We will ensure that care is delivered by the right person at the right time, that we communicate with people about their care and we plan our visits around the person’s needs. We will provide a named staff member as point of contact and we will ensure our care is coordinated in partnership with the person and their carer.”
About The Trust

Who we are and who we serve
The Trust serves the populations of the West Sussex and Brighton & Hove split into the following commissioning areas of:

• Coastal West Sussex
• Mid Sussex & Horsham
• Crawley
• Brighton & Hove

Our services are also used by people from outside of these areas, including East Sussex. Please see Appendix 1 for a full list of our services.

West Sussex
West Sussex is a comparatively wealthy county and life expectancy for men and women is higher than the national average. However, the population is relatively older than the rest of England, so the need to care for an older population is a major influence on the delivery of our services.

There are also variations in terms of health and wellbeing across the county, and some small areas of deprivation have more than 1 in 3 children living in poverty. Alcohol abuse, obesity and mental health issues are above average in the county.

The shift of public health services into local authorities, as well as the national strategic driver for greater service integration, will support the focus on improving the wider impacts on health, as reflected in the Public Health Outcomes Framework where the goal is: “To improve and protect the nation’s health and wellbeing, and improve the health of the poorest fastest”.

Brighton & Hove
According to the Brighton & Hove Public Health Report, the average woman in the city can expect to live longer than the average woman in England - 82.5 years compared with just over 82 years nationally. However, the average man will live nearly one year less than his national counterpart - 77.1 years compared with 78 years. Within the city, there are large disparities in terms of health and life expectancy between the poorer and wealthier areas.

The city has relatively large numbers of younger people (20 to 44 years), compared with the national picture, and fewer children and older people. At the same time, it has relatively more people (particularly women) aged 85 years or over.

Almost half of the city’s population is said to have current or future health needs linked to lifestyle, including sexual health, alcohol and substance misuse, cancer, smoking, circulatory disease, and mental health and suicide.
Our commissioners
The key commissioning bodies for our services include the four local CCGs; Coastal West Sussex, Mid Sussex & Horsham, Crawley and Brighton & Hove; the West Sussex Joint Commissioning Unit, as well as the local authorities; West Sussex and Brighton & Hove, who now lead public health commissioning; and the Surrey & Sussex Area Team of NHS England, responsible for the commissioning of some specialist services.

Workforce
To deliver our community and specialist services, we employ around 4,600 staff (3,772 WTE), most of whom are expert clinicians (doctors, dentists, nurses and therapists). These clinical teams deliver essential medical, nursing and therapeutic care to over 8,000 adults, children and families every day. We have a volunteer workforce of nearly 500. Their work is supported by management and specialists in areas such as infection control, governance, medicines management, information technology, human resources, finance, facilities and estates.

Board
We have a unitary board consisting of 5 executive and 5 non-executive directors and a non-executive chair. The trust is led by the board of directors. It sets our strategic direction and then monitors our performance and progress. The non-executive directors use their skill and experience gained from the private, public and voluntary sectors to help run the trust, but they do not have day-to-day managerial responsibilities within the trust. The executive directors are paid employees with clear areas of work and responsibility across the trust as well as their responsibilities as members of the board.

Business sustainability
The Trust operates within the exceptionally financially challenged Sussex health economy, but have a good financial track record and most recently met the challenge of delivering our financial targets for 2014/15. In order to maintain financial sustainability, the Trust has developed a 2 year efficiency plan for 2015/16 and 16/17, as part of a five-year programme to achieve £35m savings (3.5% of our total projected budget over the period) This should be taken in the context of planned expenditure of over £1bn over the same period. As part of this strategy, the Trust is taking forward a transformation programme, focusing on improving quality and efficiency to deliver increased productivity, in ways that will lead to better and more economic provision of the very best outcomes for people.

Our sites
91% of our care is delivered in people’s homes. Additionally, services to our local communities are delivered at 10 community hospital sites (272 inpatient beds), one registered care home, and four community service sites. We also provide services in partnership with other organisations and through other venues, for example, schools, children and family centres, private nursing and registered care homes. The estate in Brighton is owned by the Trust, while the estate in West Sussex is leased, predominantly from NHS Property Services Ltd. This is detailed in our Estates Strategy.
“Mark told us that he had become depressed with thoughts of suicide and had been referred to the SCT Time to Talk (T2T) service. Mark felt the T2T staff had pulled him back from decisions he would not want to make. He let us know that although the service was excellent, he did have to wait too long between referral and first appointment. We will shape our care around the needs of individuals ensuring that they receive care in a timely manner. Our care will be shaped around three pathways - urgent response, short term planned care and long term care. This will help people get the care they need in the right time frame.”

What we stand for
Diagram 2 details the Trust Vision, Values and Strategic Goals.

Diagram 2:

Visions and Values
Our vision and values define the future for SCT. This clinical care strategy is driven by our vision of: ‘Excellent Care at the Heart of the Community’.

To realise our vision we will remain true to our core values:
• Compassionate care - Caring for people in ways we would want for our loved ones
• Working together - As a team; forging strong links with our patients, the wider public and our health and care partners, so we can rise to the challenges we face together
• Achieving ambitions - For our people, for our staff, for our teams, for our organisation.
• Delivering excellence - Because our people and partners deserve nothing less
Strategic goals
Our strategic goals support our vision:

• We will provide excellent care every time to reinforce wellbeing and independence
• Working with our partners we will personalise services for the individual
• We will be a strong sustainable business, grounded in our communities and led by excellent staff

Delivery of our strategic goals for people
We will achieve our three strategic goals over the next four years. We will do this by assessing ourselves against our 5 year objectives.

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<thead>
<tr>
<th>Strategic Goal 1 – We will provide excellent care every time to reinforce wellbeing and independence</th>
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<tr>
<td><strong>5 year objectives:</strong></td>
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<tr>
<td>• Provide outstanding quality of care as judged by the Care Quality Commission by 2019.</td>
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<td>• Ensure that the care provided is compassionate in every case, assessed by real time feedback and where this isn't felt to be the case, review practice.</td>
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<tr>
<td>• Work with the whole systems to address the urgent and emergency care needs of people across West Sussex and Brighton and Hove, with a focus on the benefits of early community intervention and prevention of admission.</td>
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<td>• Ensure our facilities enhance the experience for people in our care.</td>
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<td>• Embed wellbeing and promotion of self care into the delivery model of the Trust.</td>
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<td>• Deliver consistently safe services through an open and transparent culture combined with good governance to ensure continuous improvement.</td>
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<tr>
<td>• In order to achieve our ambition of excellent care we will use innovative methods of service delivery.</td>
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<tr>
<td>• Co-Create and Implement the Joint West Sussex Rehabilitation Strategy with West Sussex County Council.</td>
</tr>
<tr>
<td>• Create and Implement the Trust’s Dementia Strategy to ensure the provision of excellent person centred, coordinated care for people with dementia, and support to their families and carers.</td>
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<th>Strategic Goal 2 – Working with our partners we will personalise services for the individual.</th>
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<td><strong>5 year objectives:</strong></td>
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<tr>
<td>• We will co-design services with key stakeholders.</td>
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<tr>
<td>• We will listen to what people and their carers tell us about our services and use their feedback to co-design and improve the quality of care we deliver.</td>
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<tr>
<td>• All people will feel that their care is planned, coordinated and consistently delivered in a way that considers both the most effective outcomes as well as what matters to them.</td>
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All our services are clinically effective, evidenced-based and measured against suitable benchmarks.

Co-create and implement community focused teams which provide co-ordinated, person centred care to meet the vision of our 5 Year Forward View.

Co-create and implement community focused teams which provide co-ordinated, person centred care to children, their families and carers.

### Strategic Goal 3 – We will be a strong sustainable business, grounded in our communities and led by excellent staff.

#### 5 year objectives:

- We will have the right people delivering ‘Excellent Care at the Heart of the Community’.
- Our staff will perform to a level that is commensurate with the professionalism we expect and to which they are proud to operate.
- Engage our staff in the leadership of the Trust creating a culture of excellence, and pride in the organisation.
- We will have a strong commercial offering, based upon clear understanding of the business that we are in and rigorous processes for decision making.
- We will ensure financial sustainability by all employees owning and delivering our financial plans every year, and by creating capacity for investment.
- We will support organisational sustainability by ensuring that we have the right infrastructure in place to support clinical delivery.
- We will be a strong and sustainable Foundation Trust delivering excellent care in line with our 5 Year Forward View.

Diagram 3 sets out an example of how the strategic goals are linked to our 5 year outcomes for people through a series of strategic objectives:

**Diagram 3:**

**Linking 5 year and annual objectives - Example**

<table>
<thead>
<tr>
<th>Year 2 Corporate Objective</th>
<th>Yr 2 Strategic Goal</th>
<th>5 Year Strategic Objective</th>
<th>5 Year Outcome</th>
<th>Risks to achieving Strategic objective in BAF</th>
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<tr>
<td>Q2: Implement the consolidation of community based teams through the responsive services transformation project and ensure that services are aligned to CCG community plans</td>
<td>We will provide excellent care every time to reinforce wellbeing and independence</td>
<td>Work with the whole system to address the urgent and emergency care needs of people across W Sussex and B&amp;H with a focus on early community intervention</td>
<td>Increase in proportion of fixed rate after discharge (NHS OP 3.6)</td>
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<tr>
<td>Q1: Ensure FFT meets national targets. Develop care plans for individuals who may suffer pressure damage</td>
<td>We will work with our partners we will personalise services for the individual</td>
<td>We will listen to what patients and relatives tell us about our services and use their feedback to improve the quality of care we deliver</td>
<td>FPT – or equivalent – in top quartile for similar trusts</td>
<td></td>
</tr>
<tr>
<td>Q1: Achieve and maintain 90% as the norm for appraisal rate</td>
<td>We will be a strong sustainable business, grounded in our communities and led by excellent staff</td>
<td>Our staff will perform to a level that is commensurate with the professionalism we expect and to which they are proud to operate</td>
<td>Staff overall engagement score in Top 20% all HMD organisations</td>
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Leading indicator tracked in integrated Performance Report: Eg 1. Delayed Transfers of Care 2. Friends and Family Test 3. Appraisal rates
These objectives rely on us changing the way that we care for people. The following chapter describes how we are redesigning the journey (or sometimes referred to as pathway) for people who use our services.

“Arthur aged 8 years old and his mum Sarah told us that Arthur had quadriplegic cerebral palsy and complex needs. The SCT dental service was excellent at caring for his needs but Arthur was having problems accessing our hydrotherapy pool as the hoist was not suitable to get him into the pool. Sarah also found the toilet areas not suitable to care for Arthur’s needs. We will ensure that our clinical care strategy lines up with our estates strategy to enhance the development of our buildings and equipment so that it matches the needs of the people we serve.”
Clinical Pathway Design

For our patients and their journey with our services, we work in a responsive way, similar to primary care. For patients this will mean those that require urgent attention need to receive an immediate response; those with planned short term needs will have their care carefully planned and scheduled and those with longer term conditions require coordinated and effective care.

Diagram 4:

Diagram 4 shows how our care will be delivered in a responsive way reflecting the needs and aspirations of the people we care for.

Urgent Response

We will adapt our services so that they are responsive to the urgent and immediate needs of people experiencing a crisis in their health or care. Those people, both adults and children, who need to be seen on an urgent basis, will be seen on the same day or as soon as is necessary to assess their needs, and either manage their concerns or refer them to services that can help.

Our services will work effectively with the wider urgent care network as described in the NHS England 5 year forward view. Our key specialist emergency centres in our partner acute trusts will be supported by our full range of community services e.g. urgent treatment centres and minor injury units. We will take our part in this network by preventing unnecessary hospital admissions with our admission avoidance, falls prevention and rapid
assessment teams. This may result in urgent care providers working together, in partnership agreements where entire pathways of care are managed in a formally agreed partnership.

This necessitates more coordination in urgent out of hours care. We will continue to work with commissioners to streamline the range of services on offer to people, so that there is one single point of access for all community and primary care needs outside of normal working hours.

People don’t only become unwell, or need extra care support during office hours Monday to Friday, so we will deliver services that meet the needs of people 7 days a week. We will work efficiently to ensure our efforts are focused on the times of the week when the need is greatest and move away from the perception that people’s needs must fit in with the traditional working week.

As recognised in the Keogh review of Urgent Care (2014), those people with urgent but non-life threatening needs must receive highly responsive, effective and personalised services outside of acute hospitals. We will deliver this care in or as close to people’s homes as possible, minimising disruption and inconvenience for people and their families.

**Planned Short Term Care**

We will assess those people with short term conditions e.g. musculoskeletal injuries, infections and mental health deterioration, in a timely and coordinated way, involving a range of professionals as required for each person’s needs. We will agree a care plan with each person, and explain clearly who is coordinating their care. They will be provided with a named point of contact for any queries. Their care plan will have their views included and they will own the care plan.

People want and need to be seen near to home in a timely manner by a good quality service staffed by experienced professionals. The opinion of the GP really counts when people want to know where they are being referred to. People will receive care that is joined up from the moment they are referred to when their care is complete. Diagram 5 shows how different services can fit together in one pathway or journey for a patient e.g. integrated sexual health and contraception, musculoskeletal services and dental services.

**Diagram 5:** Musculoskeletal Services (MSK) working in a coordinated way to cover the full patient pathway/journey.
The only reason that people should have to visit an acute hospital is if the intervention or treatment that they need is specialist enough to only be sited in regional centres or that the care they need can only be delivered in a specialist centre of expertise. All other care that can safely be delivered in the community will be constructed around our communities of practice.

**Long term care**

For people with long term conditions we will provide general and specialist help and support, right from diagnosis and symptom management, all the way through to supporting their carers and family. We will ensure the person has a comprehensive plan that addresses all their physical, psychological and spiritual needs. We will provide regular contact with the person at a frequency decided by the person themselves. We will provide education on their condition to fully empower the person to manage their condition and overcome hurdles along the way.

As with the urgent care networks described above, we will care for people with long term conditions in a coordinated way. We will ensure that the pathway between initial diagnosis, through to ongoing care in the community is seamless and is shaped by what matters to the person and not what diagnostic category they fit into. Organisational boundaries will be less visible as we move towards one health record shared between organisations and owned by the person.

**Care Coordination**

All the people for whom we care have a dedicated care co-ordinator. This member of the multi-disciplinary team will be the named contact for the person, and the key point of contact for other professionals who wish to gain and share information about the person. In some situations the person themselves, or the carer or parent will become the care co-ordinator.

Not only will care between professionals and the person be coordinated, it will be coordinated along the duration of the person’s health journey. So, right from the original assessment of a person’s needs, through to the prevention of deterioration in their health or social care needs, all the way through to active treatment, review and on-going management of their needs, people will only have to give their story once instead of having to explain several times to different services and organisations what they need.

The current residential and nursing home sector is under increasing pressure and some providers struggle to maintain high standards in the care that they deliver. We will work with our partners to challenge poor practice, and increase the confidence and skills of staff in this sector. By working in partnership with private care home providers we will provide training, support and expertise to improve the care of residents and up-skill the workforce.

We will develop innovative supportive roles that can be delivered by our volunteers in people’s homes.

One in three people over 65 years will develop dementia before they die. We will re-focus our work to ensure that the growing needs of people with dementia are well planned and
clearly defined. Our mental health service will be developed to meet the needs of the growing population of people with dementia; allowing those people to stay in their home. This will require up-skilling of staff to be able to deal with the complex needs of people with dementia. Along with other proactive care services, the mental health teams will visit people in their homes if people are unable to travel to services. We will continue to work actively alongside the dementia crisis teams, supporting the person living with dementia in their home.

Prevention and Wellbeing
Our staff are delivering approximately 8000 clinical contacts a day. These contacts are assessments and treatment interventions usually in the context of a particular condition. This regular contact and access to people provides our staff with the ideal opportunity to provide signposting to a range of other accessible services and/or information. We have a Health and Wellbeing strategy within the Trust and a key aim of this strategy is to equip our staff to fulfil the requirements of the “Making every contact count” initiative:-
(http://www.makingeverycontactcount.co.uk/docs/Prevention)

The Wanless review in 2002 warned us that if we did not take prevention seriously we would end up with a significant number of frail people who have a wide range of ultimately preventable health conditions. This warning was not heeded by the nation’s health systems, resulting in rapid growth of the number of people with long term but preventable illness. Nationally, we spend 70% of the health budget on long term conditions, many of them preventable. In all strands of our work on clinical pathways, we will use every meeting with a person as an opportunity for education, health improvement, prevention and encouraging well-being. This will range from advice on how to stop smoking, through to reminders that the person should undertake age related screening tests, or give support around diet and fitness. Our staff will not only focus on the medical condition they are treating but will look at the whole person in front of them, providing health and social care advice and support to promote independence.

Our staff will be trained to screen people specifically for needs relating to:

i. Weight management
ii. Alcohol use
iii. Smoking cessation
iv. Emotional wellbeing

And as part of our Health and Wellbeing Strategy we will be providing current information about a range of wellbeing resources that staff will be able to bring to people’s attention.

To achieve better outcomes for people, we need to think differently about how we educate, encourage and enable people to take control of their own health decisions and future care. Evidence suggests that only 9% of patients participate in decisions about their health. Only 50% of people follow the advice given about how to take their medicines, and only 10% of people follow advice about lifestyle changes such as increasing exercise and reducing poor diets. During consultations doctors interrupt people within 12 seconds of the person starting to talk, perpetuating directive/dependent relationships. We believe that our staff can enable people to take control of their healthy future through ‘patient activation’. Patient activation is a process by which people are educated about health related facts and gain
understanding of their health and their illnesses. With these facts, people can take action and build confidence in supporting their own health behaviours. As they become more activated to take control, they can build resilience against short term stresses and health crises.

**Diagram 6**: An example of patient activation:

Clinicians also need to become activated in supporting people to maintain their own health rather than doing it for people.

“Liz and Geoff told us that the care of their father Anthony who had recently had a broken hip and was admitted to our community hospital for rehabilitation was excellent. They did flag up concerns that his journey to our community hospital via hospital transport was long and protracted and caused Anthony great discomfort. Although SCT does not manage the patient transport system, this is an example of how the Trust can work closely with partner organisations to improve the overall pathway of care for patients.”
Quality

Achieving excellence through a culture of continuous improvement means that the quality of the care that we provide is fundamental in all that we do.

Quality is nationally recognised as being comprised of three elements:

- Patient Safety – reducing harm and protecting those most vulnerable
- Clinical Effectiveness / Patient Outcomes – care based on the best evidence
- Patient Experience – person centred care where people are treated as individuals.

Each of these elements is equally important.

This chapter describes our quality strategy and how we plan to deliver excellent quality care. It sets out some of our achievements so far and describes our future plans.

We have taken account of national recommendations and local quality priorities including:

- Robert Francis QC’s inquiry into the failings of Mid Staffordshire Hospital (2013)
- Winterbourne View review into care of people with learning disabilities and autism (2013)
- Compassion in Practice (2012)
- The Care Act (2015)
- Joint Strategic Needs Assessment (JSNA)
- Local priorities of the clinical commissioning groups, specialist commissioners and the health and wellbeing boards.

More importantly, we have taken the opportunity to ask people who use our services, their carers, staff, and partners to help inform our quality goals and strategic priorities.

People have fed back to us that:

- they support our vision and values
- they support our clinical priorities but they advise that we should focus on a smaller number of priorities to enable us to make a real difference in these areas that we should measure our quality goals and priorities so we will know that we are achieving success.

The details of our achievements against our quality priorities are refreshed annually and laid out in the Trust’s annual Quality Account, which is published in June each year. The Quality Account can be found on the Trust website: [http://www.sussexcommunity.nhs.uk/about-us/trust-reports/](http://www.sussexcommunity.nhs.uk/about-us/trust-reports/)

We will deliver our quality strategy through the implementation of our Quality Improvement Plan (QIP) which brings together, in one document, all of the actions that we need to take
over the year. The QIP includes the action plan agreed with the Care Quality Commission (CQC). The QIP is agreed annually by the Trust Wide Clinical Governance (TWCG) committee which monitors progress with the plan on a monthly basis, with assurance being provided on a quarterly basis to the Quality Committee of the Trust Board.

Diagram 7, over the page, highlights how the Trust’s strategic goals are translated into strategic and divisional quality improvement goals for the organisation. These improvement goals are owned and implemented by services, teams and individuals across the Trust.
Diagram 7: Quality Goals

QUALITY GOALS

VISION

Excellent care at the heart of the community

STRATEGIC GOALS

Excellent care every time to reinforce well-being and independence

Working with partners to personalise services

Be a strong, sustainable business grounded in communities, led by excellent staff

CQC DOMAINS

SAFE

- Harm free care.
- Medicines management.
- Mortality and end of life care.
- Resuscitation practice.

2 year deliverables achieved by:
- Patient and carer experience.
- Compassionate care.
- Learning.
- Care delivery.

5 year outcomes:
- Avoidable harm to patients will be reduced by 50%

CARING

- Patient and carer experience.
- Compassionate care.
- Learning.
- Care delivery.

2 year deliverables achieved by:
- Holistic personalised care.
- Best practice standards.
- Safeguarding children, young people and adults.
- Business intelligence and community nursing.

5 year outcomes:
- A positive patient experience will be achieved in 80% of patient interactions measured

EFFECTIVE

- There will be a well-defined suite of outcome measures in 90% of services to be able to demonstrate year on year improvements towards Outstanding

RESPONSIVE

- Accessiblity.
- Responsive to need.
- Parity of esteem.
- Early warning systems.

WELL-LED

- Leadership.
- Staffing and recruitment.
- Staff development.
- Culture.

2 year deliverables achieved by:
- 80% of services will meet the needs of service users

5 year outcomes:
- 90% of staff will have undertaken skill competency assessment and leadership training as appropriate to role

Excellent care at the heart of the community
The improvement outcome measures for year two are highlighted in Diagram 8 which moves us on our journey towards our five year quality goals.

**Diagram 8: Quality Targets**

- **SAFE**
  - Year 2: Reduction in harm & improvement in harm free care by a further 7%
  - Year 5: Avoidable harm to patients will be reduced by 50%

- **CARING**
  - Year 2: Positive patient experience will be expressed by 20% more patients
  - Year 5: A positive patient experience will be achieved in 80% of patient interactions measured

- **EFFECTIVE**
  - Year 2: Develop the skills and mechanisms to deliver evidence-based, individualised care to patients and their carers and report on it.
  - Year 5: There will be a well defined suite of outcome measures in 90% of services, and to be able to demonstrate year on year improvements towards Outstanding

- **RESPONSIVE**
  - Year 2: Develop and implement systems and processes that support equitable care and treatment, that is responsive to need.
  - Year 5: 80% of services will meet the needs of service users.

- **WELL-LED**
  - Year 2: Roll out of Trust Competency Framework with 20% clinical staff completing their competency assessment and 20% of staff in leadership roles attending leadership training.
  - Year 5: 90% of staff will have undertaken their competency assessment and leadership training where applicable.

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23 Excellent care at the heart of the community
Achievement against the priorities set for 2014–15
Most of the priorities we set ourselves for 2014/15 have been achieved (Appendix 2) and those targets that we have not met have been refreshed and included in the 2015/16 priorities.

Last year our biggest achievement was the awarding of a “Good” rating by the CQC following a full inspection; with 18 of the 20 indicators rated as good and with our End of Life Service being rated as “Outstanding”.

There are still areas for improvement identified by the CQC, included in the resulting action plan, and these recommendations feature strongly in our quality priorities for next year.

Key quality goals for 2014 – 2019
We have established a number of 5 year quality goals and have already made some progress towards achieving them. To ensure that we can maintain progress towards these goals we have set ourselves some measures of success. The detailed targets and trajectories for achieving these goals are included in our 5 year QIP.

Safe Domain – 5 year Quality Goal

Our Goal for safe care is:
To provide safe care every time, reinforcing wellbeing and independence and achieving an ‘outstanding’ rating by the Care Quality Commission across all services.

We will achieve this by:

Reducing avoidable harm overall by 50%

Harm free care
Harm free care includes preventing people: acquiring pressure damage; falling in our care; contracting hospital acquired infections; contracting catheter acquired infections; acquiring a venous thromboembolism (clot); and suffering from medication errors.

We will continue to train staff in the skills needed to assess and prevent falls by using the latest technology, such as sensor mats and electronic patient alerts.

We have a zero tolerance to avoidable pressure damage to patients where the damage is attributable to our care. This includes preventing pressure damage deteriorating over time.

We have implemented a prevention strategy and framework for delivery, with many staff already trained in its usage. We also recognise that, for the majority of people, they are being cared for in their own home so we will support carers to recognise skin integrity. We have developed a carer’s toolkit which is now being implemented.

23 Excellent care at the heart of the community
We have a zero tolerance of preventable transmission of healthcare acquired infections and continue to reduce the number of outbreaks in our inpatient units.

We will extend our regular hand hygiene audits in our inpatient units to carry out audits in our community services. This will ensure good infection prevention and control practice is carried out in people’s homes and other settings.

**Medicines Management**

It is important that patients receive the correct medication, via the correct route, at the correct dose, at the right time. Errors potentially occur in the process of prescribing, dispensing, preparing, administering and providing medicine advice, regardless of whether any harm occurred.

One of the key priorities is to reduce the number of medication errors causing harm to patients as well as reduce the number of missed or omitted doses for patients in our inpatient units.

**Mortality and End of Life Care**

We have introduced a system for reviewing every death that occurs within our care. This is to provide our staff with valuable information on how to make sure that our patients experience effective, compassionate care at the end of their lives.

**Resuscitation**

We will review our training, policies and processes for resuscitation to ensure they are aligned with the Resuscitation Council UK guidelines and ensure we have consistency of standards across all our services.

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**Caring Domain – 5 year Quality Goal**

**Our goal for the Caring domain is:**

That we will provide excellent, compassionate care to people every time to reinforce well-being and independence.

**We will achieve this by:**

Ensuring a positive patient experience in 80% of patient interactions measured

We expect all of our patients to be treated with compassion, dignity and respect and our teams want to know, learn and improve from circumstances where this does not happen. There are a number of ways we can listen to patients and improve their experience to make sure we achieve this goal.

**Patient and Carer Experience**

We recognise that how staff communicate and deliver care makes a difference to an individual’s perception of the care they receive. We use a variety of feedback mechanisms to do this, including talking to patients, surveys, and announced and unannounced visits to
service areas. We use trained staff to watch how others interact with patients, called ‘Sit and See’ observations.

We recognise that having information on how patients are experiencing our care at the time that it happens would help us respond more swiftly. We will be introducing technology solutions that allow us to assess the information that patients give us about their care in real time.

We will use patient surveys and promote the use of the Friends and Family Test to understand what service users think about the services we deliver and use the results to improve care. Where feedback identifies areas of good practice we will celebrate this with staff.

Carers play an essential role in the care of the patient and so, using the principles highlighted in the “Triangle of Care” (2013) document, we will ensure staff identify, listen and talk to carers when undertaking holistic assessments of patients, and seek and acknowledge carer’s views and needs as part of that assessment.

**Compassionate Care**

We are determined to move from a culture where clinicians ask “what’s the matter with you?” to one that has us working with patients to ask “what matters to you?” We are going to roll out ‘Sit and See’ to our community teams and are expanding the ‘Sit and See’ tool to see how staff introduce themselves as part of the national “hello my name is…” campaign.

Customer care training has been developed to support staff and reduce the number of complaints related to staff attitude. This will be implemented across all staff groups and we will monitor whether this has a direct impact on the complaints received. At the same time we are determined to reduce the time it takes for us to respond to complaints.

**Shared learning**

To ensure excellent compassionate care every time, we need to be certain of the consistency of care. To help us with this we will share and learn from what works well across the organisation, using national benchmarks of good practice, evidence based practice and Royal College standards as well as learning from similar services in other organisations.

Shared learning events already take place and peer review processes are also being explored to allow staff to constructively review each other’s areas of service provision. We are arranging ‘buddying’ with another organisation to peer review each other’s services to provide a wider learning opportunity.

**Care Delivery**

An independent review undertaken by Age UK and the Department of Health into hospital food standards (2014) highlighted the importance of assessment and good nutrition in order to improve recovery and prevent complications for inpatients. It also highlighted the complications to health that obesity and poor eating choices can have on the child and adult population.
The Trust has set targets to address these issues and we will be working with our patients, carers and staff to ensure that people’s nutritional and hydration needs are assessed and addressed. This will include a review of the protected meal time process to ensure it is achieving its aim of improving nutrition and hydration.

The CQC encouraged us to learn from pain management techniques used in acute hospitals to improve our own pain management processes in order to guarantee that people in our care receive appropriate, consistent and timely relief from pain. Following this recommendation we have already begun to review our pain assessment tool and will standardise this against best practice. Consequently we will adjust our pain management training so that staff can be aware of and use effective pain management techniques.

### Effective Domain – 5 year Quality Goal

**Our goal for the effective domain is:**
That people will feel that their care is planned and personalised by working together to understand both their needs and their carer’s needs.

**We will achieve this by:**
Developing a well-defined suite of outcome measures in 90% of services to be able to demonstrate year on year improvement towards outstanding

### Holistic Personalised Care

Incident and complaints responses and the CQC have highlighted that record keeping and care planning across the Trust could be improved in some service areas to ensure consistency and to ensure the care delivered is personal to the needs of the individual.

We are increasing our regular records audits and advancing the implementation of our electronic health record system which will support the safe transition of records between teams and other service providers. We are sharing all incidents where the information received or given was not of the level needed for excellent care.

Standards for care planning have been developed and this documentation is being piloted and, when learning has been incorporated, will be implemented across the Trust. As part of this process it will be made easier for the patient to know their named care coordinator and how to contact them and we will continue to develop and roll out personalised care plans for carers.

### Best Practice Standards

Care needs to be based on sound evidence and research and we already actively take part in research and clinical trials. Working closely with our partners in research activity we will encourage clinicians to engage and lead (as well as participate) in active research projects for the benefit of improving health outcomes. NICE quality standards will also be incorporated into clinical audit tools.
Safeguarding Children, Young People and Adults
Ensuring all vulnerable children and adults are safe whilst in our care is a priority for the Trust and the safeguarding adults team has recently been expanded to ensure execution of the requirements of the Care Act (2014). We work closely with the local authorities (who have lead responsibility for safeguarding) to ensure multi-agency working and to ensure training programmes are in place for staff.

The recommendations from the Lampard review (2015) have been reviewed and are incorporated in the QIP. Additional training is being delivered in relation to the ‘prevent’ agenda to ensure staff know how to detect, assess and work with other agencies to protect those vulnerable individuals at risk of radicalisation and extremist activities.

Community Nursing and Business Intelligence
Complex care once delivered in hospital settings is now being provided in community settings. As such a growing number of older people and people with long term conditions are being cared for in their own homes which has a significant impact on the levels of dependency in the community and therefore on the working caseloads for community nurses.

As part of our approach to population care we have developed a new vision for community nursing that will promote the notion of support, care and independence. To create the environment in which this can happen we are currently in the process of assessing the competence of our multi-specialist practitioners and introducing clear clinical leadership with both generic and advanced skill sets.

Our informatics strategy implementation plan will ensure clinicians have access to real time data. This places emphasis on the importance of real time quality information and the application of business intelligence to demonstrate evidence of quality improvement. Some of our specialist services, e.g. palliative care, have developed effective quality metrics to demonstrate improvements to clinical outcomes and the effectiveness of their interventions. These indicators will now be rolled out into smaller services e.g. diabetes care.

Responsive Domain – 5 Year Quality Goal

Our goal for the responsive domain is:
We will work with partners to personalise care.

We will achieve this by:
Ensuring over 80% of services meet the care needs of service users as assessed by a range of feedback mechanisms

Accessibility
Last year we completed an audit of services against the six national criteria for meeting the needs of our patients and carers with learning disabilities. We want all people with learning disabilities (LD) to feel that their views matter, that they have a voice in their care and that they are able to express opinions in whatever way is appropriate to them. We
will increase the numbers of LD champions within services, who will be offered additional training in ways to support people with LD. We will also shape the way we communicate and obtain feedback from people with LD in a personalised, clear and accessible way and review and develop user friendly information across our services.

For children we are working to achieve person centred coordinated care in children’s services by responding to what service users have identified is important to them. (A Narrative for Person-Centred Coordinated Care 2008).

This is particularly important when children and young people transition into adult services especially if they have a physical disability/complex health need. As such we will be ensuring transitioning plans are in place for each individual and they have a named SCT lead as a point of contact.

**Responsive to Need**

The Trust’s vision is supported by a specific ambition for equality and human rights of ‘equitable care at the heart of all our communities’. An equality and diversity engagement plan is in place and, following people engagement, the objectives will be renewed and a revised strategy will be published.

The Trust manages cross-agency agreements for the external provision of accessible communication support for disabled people and spoken language interpreting and translation services. Additionally the Trust will continue to maintain its disability positive (two-ticks) accreditation as an employer.

**Parity of Esteem**

It is recognised that good mental health is as important as good physical health. Among people aged 65 and over, nearly half of all ill health is mental health (NHS England, 2014).

We will be developing a mental health assessment screening tool that staff will use to assess people’s mental health needs and provide staff training in its usage. We will also be working with our mental health partners to ensure smooth transition between mental and physical health services.

It is estimated that there are 13,000 people living in West Sussex alone that are suffering with dementia and that this is set to grow by 26% by 2021. The Trust has recognised that carers of people with dementia are often frail themselves and also require support after a diagnosis has been made.

As such it is important that we concentrate on prevention, early diagnosis and assessment, sign-posting to other appropriate mental health services and enhancing the skill set of our staff in order to ensure people who use our services receive the right help at the right time.

We have assessed ourselves against the Department of Health (DH) dementia assessment tool and will be rolling out training to all staff as well as embarking on an estate refresh of our inpatient units to ensure the environment of these units is suitable to care for patients with a diagnosis of dementia.
Early Warning Systems
We are using our early warning system to alert us to service areas who are working under pressure due to levels of staff sickness, vacancies or other factors such as increasing numbers of patients needing to be seen. We aim to build on the quality early warning trigger tool (QEWTT) and escalation processes across the Trust to build a culture of safety, ownership and leadership. This will allow staffing levels to be triangulated against levels of harm (such as falls) to see if there is any direct correlation.

Well – Led Domain – 5 Year Goal

Our goal for the well-led domain is:
We will be a strong, sustainable business grounded in communities, led by excellent staff.

We will achieve this by:
Ensuring 90% of staff have undertaken their competency assessment and leadership training, as applicable to role.

Leadership
Involving clinical staff in decision making, developing the skills of those delivering care and allowing staff the time to reflect and review care delivery is essential. Leadership of clinical services is a crucial component of effective and excellent clinical service delivery and the Trust’s leadership structure includes clinical directors working with heads of service at a senior level together with senior locality nurses, deputy chief nurses, associate medical directors and heads of therapies.

During the unprecedented challenges that the NHS is facing and the changes required in the NHS, it is timely to review our leadership strategy and ensure that we have effective and capable leaders in place to ensure a clear sense of direction, purpose, contribution and ownership.

Staffing and Recruitment
We have improved our staffing levels across our inpatient units. Safer staffing papers have been regularly reviewed by the Trust Board and the Trust has displayed and reported its staffing levels for inpatient units, as nationally mandated.

Registered nurse staffing levels however still continues to be a significant challenge for the organisation and as such this remains a high priority going forward.

We have completed a review of community nursing staffing levels and in the absence of national guidance we are developing metrics for reviewing safer staffing levels in community nursing, which will support our commitment to re-shape community nursing to meet the changing needs of the population.
We are strengthening our workforce planning in the Trust to allow us to commission the right number of student placements which will ensure sufficiently qualified staff are available when required.

**Staff Development**

We recognise that effective staff development is key to providing excellent care. This is achieved by:

- Induction, statutory training and appraisal.
- Supporting continuous professional development (CPD).
- Leadership and management programmes for middle managers.
- Clinical supervision, safeguarding supervision, mentoring and preceptorship for newly qualified staff.

We also need to ensure that people have time for reflection and that our substantive staff have the skills to be able to mentor and supervise them appropriately, both as students and when they start employment with us as newly qualified staff.

A framework is in place for preceptorship of newly qualified staff and a review of the framework for clinical supervision and mentorship will now take place to ensure it adequately reflects requirements and is consistent across the organisation. Metrics to identify if placements are of a good quality for students will be developed and monitored.

A competency framework has been developed, piloted, and roll out has commenced for nurses and allied health professionals to ensure staff have a universal level of competence and skill set relevant for their grade.

**Culture**

The way care is delivered is of significant importance, which is why the Trust’s values and behaviours are so vital in contributing to our culture of achieving excellence through continuous improvement.

Through our cultural development programme we are building on our existing cultural and leadership mechanisms to ensure we achieve the culture that our staff told us they want, as part of our work following the publication of the Francis Report:
• Treating others as I would wish to be treated; with respect and courtesy
• Work with patients and carers as equal partners and talk with them, not at them
• Act in a professional manner at all times and take responsibility for my own behavior
• Show respect to colleagues and actively support positive behavior
• Be approachable and actively listen to what people have to say
• Be open to learning and improvement.

We have signed up to the “hello my name is…..” campaign (Dr Kate Granger) and made safety pledges (‘Sign up to Safety’ campaign) to reduce harm in the NHS. The independent report “Freedom to Speak Up” (2015) highlighted the importance of staff being able to raise concerns in an open and honest fashion without fear of reprisal. We will review and revise our Raising Concerns Policy and Procedure, and areas of concern raised by staff are to be monitored in future by the Trust Board directly so trends and themes can be identified and action taken.

National 6 Cs in Action
Integral across all the quality priorities is the belief that people should receive the ‘6 C’s’ when in our care, as described in the national “Compassion in Practice” programme (2013).

The 6 C’s are:
• Care
• Compassion
• Competence
• Communication
• Courage
• Commitment.

Staff within the organisation discussed the campaign and decided to include a 7th ‘C’ for consistency of care across our services to link in with some of our goals for improvement, and the 6 Cs feature as a thread throughout all of the quality goals for the Trust.

This is demonstrated as follows:
The safe quality goals relate to the commitment needed to continually improve the quality of care and continually increase harm free care by looking at new initiatives and new treatments.

Compassion and good communication is required to care for people every day, to ensure their voice is heard and that they are safeguarded from harm.

To be effective, staff have to have the courage to try new ways of working and develop new models of care, and to review their own practice and be open and transparent in communicating their findings.

In order to improve access and equity of service it is important to develop consistency and ensure systems and processes that allow equity across all services so service users
can expect the same high standards of care wherever they live and wherever they access our services.

To ensure all of the above happens, staff need the competence to deliver and maintain highly technical clinical procedures and lead teams of practitioners and students to deliver safe care.

**Ensuring excellent care through good governance**

Assurance to the public and our commissioners that our services deliver quality care is given through the effective functioning of the Trust Board.

We are committed to reporting quality outcomes in an open and transparent way that is meaningful to people.

The Trust Board receives a monthly quality report as part of the integrated performance report. This includes the quality dashboard and an exception report identifying where services are performing well or where improvements can be made so plans can be put in place to address any adverse trends.

Detailed quality assurance reports are reviewed at the bi-monthly Quality Committee of the Board, which provides additional information on progress against specific quality improvements.

Executive directors and non-executive directors visit services in the Trust. They get first-hand experience of the successes and challenges faced in each service.

The Trust Wide Clinical Governance committee membership includes directors, senior clinicians, managers and frontline staff who analyse in-depth quality issues, which are escalated to the Executive Team and the Quality Committee as necessary.

Other groups (including: Infection, Prevention and Control; Safeguarding; Health and Safety; Patient Experience; and Medicines Management) feed into the Quality Committee’s work to ensure there is a good flow of information from service delivery through to the sub committees of the Board and the Trust Board itself.
Clinical Delivery – Our Operating Model

The clinical pathways and quality of care for our patients journeys have been described in the previous chapters. Now we will set out how we will effectively deliver this coordinated care which will involve reshaping how we organise our services.

We will deliver this population-focused health and social care through individualised care focused around local communities of practice which naturally form around GP surgeries, children and families centres and schools. Each community of practice will contain between 50,000 and 100,000 plus people and would include all children and adults who live in that locality. The communities of practice are the core operating service delivery model for each community. When specialist care is needed e.g. the advice and support of a tissue viability nurse, this will be provided from a wider locality base (a locality being a group of communities of practice). Our trust will develop to ensure we have the right approach to management and leadership of the communities of practice to enable the teams to work autonomously and collectively and at the same time for the Trust to agree clinical standards of best practice and outcomes for specific local communities across the Trust.

Our organisational structure will be transformed to ensure we have the right staff with the right skills to meet the needs of the population of each locality. There will be local joined up management of services which will be fully coordinated with our partners in social care, mental health, and voluntary sector, as well as other health and private providers. If we view localities of people with adults and children together we will reduce or eliminate the problems associated with transitioning between children’s and adult services.
Communities of practice (see diagram 9, over the page) are naturally forming across our geography within the following areas:-
North West Sussex: Crawley, Horsham, East Grinstead, Haywards Heath and Burgess Hill.
Coastal West Sussex: Adur, Arun, Regis, Worthing, Chichester and Chanctonbury
Brighton and Hove: 6 localities currently called ‘clusters’.

Every person will be supported by a multidisciplinary team including primary care (e.g. GP, dentist, optometrist, pharmacist) and more generally supported by community services (e.g. Community Nursing, Domiciliary Care, Health Visiting, Mental Health and Social Care).

**Diagram 9: Community of Practice**

At a locality level (groups of communities of practice), people will be cared for and supported by integrated care teams including the voluntary sector and specialist community services. Community hospitals are the centre of community care for people. When people are acutely unwell they will be ‘on loan’ to the local acute general hospital which sits outside of each locality.
Diagram 10: How the communities of practice form localities

Our four major commissioning areas (Coastal West Sussex; Crawley; Horsham and Mid Sussex; and Brighton and Hove) together form our Trust’s area of operation.

This changes the way that our teams work together within communities of practice and localities. We will ensure that although care is individualised to people within each community. We will achieve this through peer support, opportunities for professional practice training and development, supervision from staff in different localities and the flexibility to move our staff between localities to develop their skills and competencies.

Whilst communities of practice focus on the general needs of that local population, we won’t forget those people that have specific specialist needs that require expertise from staff in other areas of our Trust. We have the flexibility to share subject experts across our Trust to provide specialist advice to our generalist staff in the communities of practice.

The delivery model described above fits together with a person’s pathway/journey as described in the Clinical Pathway Design chapter (urgent response, planned short term care and long term care in the following way.)
Diagram 11 – how the communities of practice delivery model fits together with a person’s journey of care.

Our staff and volunteers live in the communities that they serve. We will work with our volunteer workforce by recognising that our organisation is a community asset, providing the local community with the opportunity to contribute their experience, knowledge and skills to give something back to society. We recognise that our volunteer workforce contribute over 940 hours a week of unpaid hours to enhance and improve the experience of people who use our services.

The aim of the model is to deliver excellent care in the communities where people live and by structuring our services around the needs of each locality, we will be in a better position to respond quickly to changes in people’s health and care needs, as well as be able to ensure we have the right services near-by to prevent health and social care deterioration. The advantage of this community based model of care is that it is ‘scalable’. This means that we can replicate the model as we move into new areas of care for other communities in our surrounding areas.

As more people are now living on their own, we will develop our services that support local carers to look after people and educate people to look after themselves. We recognise that the voluntary carer ‘workforce’ is the largest workforce in our area (1.2 million full time unpaid carers nationally) and the needs of those carers are currently unmet. We will focus our services on identifying carers, recognising their needs and supporting them, together with our partners, to energise them to continue caring in a supportive manner.
Partnerships

Increasingly we will partner with other organisations to provide true individualised care for people. We have started aligning our strategies with our partners, to ensure that shared priorities are coordinated to ensure effective outcomes for people.

One important partnership is with primary care – which includes GPs, practice nurses and local pharmacies and optometrists. The benefit of coordinating our care with local GP surgeries, children and families centres and schools, is that we can work in partnership with primary care staff to deliver joined up person centred care. Benefits will include our ability to support practice nurses in community health care tasks e.g. chronic skin condition management, and practice nurses can support our staff in management of chronic diseases. This will allow greater flexibility in caring for people as the staff will be able to work together to address the needs of each person in a holistic manner, supporting those that visit the surgery and those that are at home.

We recognise that not all people live in owned or rented homes, but need care within a different setting e.g. children’s home, nursing home or residential home. We will adapt our services to work alongside our partners in these sectors to fully support them to deliver safe high quality care. We will both educate and learn from the staff working in these sectors to increase the local knowledge about how to help and support vulnerable groups.

Different health and social care organisations work together in what is known as the local health and care ‘system’. We will continue to play our part in that system, by supporting the local acute trusts to reduce the number of people who attend the hospital unnecessarily and also by supporting people back into their home when they have been discharged from hospital. We will also work differently by supporting acute trust professionals to come out into the community to deliver care closer to people’s homes. We will increasingly use specialist expert help from across the system to clinically lead and support the delivery of care to people with long term and complex conditions.
Transformation

In order to deliver the future described in this strategy the necessary resources and infrastructure needs to be in place. Our IT, information, estate, people and processes will need to be set up ready to support the clinical services in five years’ time. This in turn requires planning that matches the journey we will be taking in clinical care delivery and at the same time we are making these changes in a challenging financial and commercial environment.

There are underpinning strategies that describe these parallel developments in:

The People Strategy
Our People Strategy describes what it will be like working in teams in SCT in five years’ time and, further, what leadership and development support people can expect. It describes:

- Working in multi professional and multi-agency teams that are autonomous and responding to a culture of continuous improvement toward excellent care.
- It describes an approach which always has the individual at the centre of care with practitioners supported and confident to work with the person, child, family and carers to achieve the goals the person has chosen.
- It talks of a workforce that is proud to work for SCT and to the organisations values; who are inspired to continuously improve the care they provide; are fully engaged in shaping the future for the Trust and who participate in education, development and research.

The Informatics Strategy
The Informatics Strategy makes the link between the present and future for people, our staff and communities through the provision of information and the use of technology. Using technology and information effectively will make it more possible to achieve our strategic goals over five years.

- It will need a single person centred record that is shared, and governed appropriately, with all the practitioners involved in the person’s care having real time information on their health and wellbeing.
- It talks of the benefits to be seen with telemedicine, telecare and mobile working used by professionals, people and their carers and families in supporting wellbeing and independence.
- It explains the business benefits of having the data and information to help staff make sensible clinical and managerial decisions and it considers the necessary IT – hardware and software needed to make all of this happen.

The Estates Strategy
The Estates Strategy driven by the models of care described in this Clinical Care Strategy is also closely linked to the Informatics Strategy as well as to the People Strategy. Working in communities, wrapped around GP populations of 50-100,000 people, with the technology to support a mobile and flexible workforce means that our estate needs will be very different.

- Staff will be based in the communities in which they practice
• Working with all local agencies it will be possible to make the most of local estate and share specialist facilities like imaging
• The estate (and IT) will support the use of multi-disciplinary, multi-agency teams
• Being flexible in our work and estate will mean we can organise ourselves to bring together different professionals in clinical accommodation to meet the needs of people rather than our departments
• The state of the environment in which we work is worthy of our population and support our Care Without Carbon environmental expectations

The direction of the Trust set out in this Clinical Care Strategy is in tune with the principles of sustainable healthcare identified in Care Without Carbon (CWC) our strategy for sustainable healthcare

The Commercial Strategy
The commercial environment for community services is described in our commercial strategy with some key components being:
• Procurement of services as pathway improvements and integration are designed by commissioners. This offers opportunities and threats which we mitigate by being confident that our clinical care strategy describes a future aligned to local and future commissioner visions.
• Being connected into our customers and markets, current and future.
• Recognising that our staff are our greatest asset.
• Having a clear and realistic ambition for growth while embedding and improving local services.
• Understanding that our strength in the market place is in our ability to achieve and demonstrate achievement of our vision of Excellent care at the Heart of the Community

The Transformation Plan
Each of these strategies is associated with a specific action plan and we bring all of them together in our Transformation Plan which, using the Managing Successful Programmes (MSP) methodology, makes sure that the sum of their parts delivers the Transformation in services we describe in this Clinical Care Strategy.

The Transformation plan describes the programmes and projects that we have put in place to deliver the clinical care strategy and the governance by which we will measure the success of these programmes. The four strategic themes in our Transformation Plan are:

• Integrated care and support for adults.
• Children and families integrated care and support.
• Specialist and community care and wellbeing.
• Organisational Design.
The Transformation Plan is aligned to the Service Development and Improvement Plans (our business plans) that are described in the Trust’s overall Integrated Business Plan (IBP); in turn these inform the five year financial plan the Long Term Financial Model (LTFM) which demonstrates how we are going to be sustainable while delivering the strategy.

**Long Term Financial Model**

The Trust has a strong history of financial performance since it was formed by merger in 2011, delivering each year against its agreed financial plan. The inherited underlying financial deficit in the West Sussex community provision has been addressed with recurrent efficiency savings, and a financial delivery infrastructure is in place which creates integrated financial, activity, workforce and quality plans each year. The impact on the Quality of Care is assessed for each of the financial plans and other change programmes, and these are reviewed on behalf of the Trust Board by the Quality Committee. The level of annual efficiency savings required has fallen from over 5.5% to around 4%, and the service developments that are being made support the health of the organisations finances.
Looking forward, the Trust faces a significant financial challenge alongside the rest of the local system. It operates across four financially-challenged local health economies, but has shaped a role for itself as an organisation which delivers high quality services at a price which is affordable to commissioners and, where appropriate, delivers savings and benefits for the whole health and social care economy. The Trust’s Transformation Plan describes the future state of the organisation, and creates the pipeline of transformational schemes which will deliver the required quality and financial benefits. On an annual basis, these schemes move into the annual efficiency programme.

Our long-term financial model (LTFM) takes account of changes in national and local financial circumstances, and models our plans around changes in activity, workforce, inflation and expenditure. The LTFM shows the efficiency challenge for the Trust is £35m over the next five years. This should be taken in the context of planned expenditure of over £1bn over the same period. The Trust has detailed savings plans in place for the next two years, and a series of plans and programmes for the longer-term which, taken together, more than meets this challenge.
Success

The Suscombe family – what care could look like in 4 years time….

The Suscombe’s have lived in their neighbourhood since the 1950’s and have seen some changes. Mrs Suscombe is 72 and has Chronic Obstructive Pulmonary Disease (ex-smoker), diabetes and chronic leg ulcers, secondary to obesity. She is now house bound and relies on regular visits from her community nursing team to support her family in learning how to manage the dressings for her ulcers. The nurses visit regularly to review and redress her ulcers are doing and they arrive at a mutually convenient time for the Suscombe family. Although she doesn’t see the same nurse every single visit, she has a regular nurse who visits and coordinates with the rest of the team; Mrs Suscombe can contact her at any time via email or phone. Her diabetes is now largely under control due to Mrs Suscombes self management of her diabetes. She went on a short course together with her daughter and husband and they now feel able to manage the highs and lows of her sugar changes. When her diabetes plays up the specialist diabetes nurse who works with the nurses at the surgery and the community nurses calls or visits to suggest what to do next. Mrs Suscombe rarely needs the GP but when she gets excessively wheezy from her COPD, the GP calls. She already knows all about Mrs Suscombe’s progress because the medical records are shared between the GP surgery and all the other people who help Mrs Suscombe. The GP can also see her update oxygen saturations which are recorded on the machine at home and the results sent to the surgery. When her ulcers are playing up the GP and tissue viability nurses review it on the tele-medicine screen which links Mrs Suscombe’s computer to the health centre computer. The local diabetes charity put on events that Mrs Suscombe enjoys attending including shows from the local secondary school and interesting talks from chosen speakers. She gets out and about with the help of volunteer drivers who work in partnership with the health transport system which is based in town.

Mr Suscombe was a labourer before retirement. He suffers from a chronic bad back and joint pains but can get around on his own. When he has a flare up of his pain, he visits the physio and gets an appointment very quickly. He sometimes has hydrotherapy at the community hospital. All his appointments are planned around his activities – he plays golf and is a member of the local church and community centre committee. He plans his care with his physiotherapist and decides his own goals at each stage. He has a copy of his plan at home and can call or email the physio when he needs advice on his exercises. Last year the pain got him down so much that he started to feel depressed and was
anxious about going out. He self-referred himself to the Time to Talk service who spoke with him on the phone about his concerns, put together a programme of support with him and communicated with his GP so that he could start some medication at the same time. Everything came together in sequence and he is now on top of the world. Mr Suscombe tends to find he has a lot of caring duties especially when his wife is poorly. He has a social worker who works in the team who look after his wife and he has been assessed to find out what his needs are as a carer. He decides what he does and doesn’t need and he and his wife control how the money is spent on them to make sure it is used to their maximum benefit.

Mr and Mrs Suscombe’s daughter and son in law, Joanne and Anand live across town and they both commute to London everyday. They have two children and don’t want any more so they popped into the contraception and sexual health service for an evening walk-in appointment and received the advice that they needed. Joanne is well considering she had a difficult pregnancy and gave birth to her baby girl Kelly, 9 weeks prematurely. After leaving hospital the health visitor visited and knew all about what had happened as she had been in communication with Joanne’s midwife throughout the end of the pregnancy. The health visitor spent quality time with Joanne advising her on how to manage the ups and downs of a new born baby. At times Joanne was low and struggling, but the health visitor responded quickly and got Joanne into a local support group of mums in a similar situation. The health visitor was excellent at reducing Joanne’s anxiety but also about teaching Joanne how to care for Kelly and make sure she grew up strong and healthy. The health visitor works in the same team as Joanne’s GP and also the community nurses who look after Mrs Suscombe. They have known the family for years and know just when they are struggling and what to do to help. Joanne and Anand’s son, Kamil is now 6 years old and has cerebral palsy and epilepsy. Since birth he has been under the care of the children’s community nursing team and he has had the same named nurse throughout this time. The nurse is coordinator of all his care in partnership with Joanne and Anand. If Kamil is unwell they can call the community team at any time for advice. Joanne and Anand hate taking Kamil to hospital (Kamil hates it too) and so they have received training and advice from the community nursing team on how to manage his condition. If in doubt they can call for advice. Kamil had a tube into his stomach to help him feed when he was smaller and Joanne and Anand remember how helpful it was to have the nurses provide advice and support on how to manage the feeding. Kamil rarely sees a doctor, but when his medicines need changing or anything new comes along, he sees the doctor at the child development
centre, where, in the same appointment he also gets to see the speech therapist, physiotherapist and occupational therapist (OT) in one coordinated joint assessment. Joanne finds this helpful as it is hard to keep travelling for different appointments all the time.

Anand’s family come from Kerala in India and all live in the same town. Anand has a family history of heart disease and is doing his best to stay fit and healthy to avoid getting it. There are a lot of people in this town with heart problems and diabetes and so the town has a small team of health and wellbeing advisers who work alongside GPs in providing advice and training on how to stay fit and healthy. Anand attends the gym once a week, and the diabetes specialist nurse does a drop in clinic there every few months to check on him and his friends. Anand attended a healthy eating event at the surgery where a chef cooked up some interesting dishes which were good for people with concerns about heart disease and diabetes. All the people helping Anand and his family to stay fit work together so if Anand is worried at any stage, any member of the team knows about the exercise programme and diet he has been on.
Summary

Our clinical care strategy is about people: that the care we provide is excellent, their voices listened to, that all our staff value compassionate care and we use all of the tools available at our disposal to constantly improve the quality of our care.

Maintaining the focus on quality will be our prime driver as we transform our services, deliver care around community needs and become more person centred as we individualise care. We can't do this alone and so we will continue to develop strong relationships and partnerships with other health and social care providers, community groups, charities, commissioners, public health and others.

We will continue to use all the mechanisms available through clinical governance, quality assurance, risk management and audit to ensure what we do is safe, effective and supports people and staff in every care encounter.

Quality is, should and will always remain the highest of all the priorities for Sussex Community NHS Trust.

We welcome comments about our clinical care strategy and developments we propose. If you feel you would like to comment on the strategy please contact a member of staff, the manager of the service you are using, PALS or the Chief Executive.

For further information on SCT please visit our website: www.sussexcommunity.nhs.uk

Paula Head, Chief Executive
01273 696011 ext. 3545

PALS and Complaints
FREEPOST (BR117)
Elm Grove, Brighton BN2 3EW
Tel: 01273 242292
Email: sc-tr.serviceexperience@nhs.net
Appendix 1

Our services
The Trust’s community and specialist services are delivered from over 300 locations across West Sussex and Brighton & Hove, including community beds in West Sussex. We interface with three local acute trusts; Surrey and Sussex Healthcare NHS Trust (SASH), Western Hospitals NHS Foundation Trust (WHFT) and Brighton and Sussex University Hospitals NHS Trust (BSUH). Our Estates Strategy articulates how our estate will support the delivery of our clinical services.

Our services are delivered through two market segments:
1. Adult Services
2. Children and Specialist Services

Sussex Community NHS Trust Service List

Adult Services

- Assessment and intervention team (West Sussex)
- Bladder and bowel service
- Integrated Response Team (IRT)
- Clinical Assessment Unit (CAU)
- Community admission avoidance team (RAIT (CWS) AAT (NWS), CRRS (B&H))
- Community intravenous therapy service
- Community neuro-rehabilitation and stroke community team.
- Community Nursing and Integrated Primary care Teams
- Community Short Term Service (Brighton and Hove) (incl. ICS)
- Community single point of access – OneCall (West Sussex)
- Continence Service
- End of Life Care
- Falls and osteoporosis service
- Inpatient beds in our Community Hospitals
- Intermediate care WSX and CRRS SEE above)
- Management of conditions such as heart failure, chronic obstructive pulmonary disease, diabetes, lymphedema, Parkinson’s, MS and motor neurone disease
- Minor injury units (Bognor, Horsham)
- Multi-disciplinary and multi-agency proactive care teams
- Night Sitting Service
- Overnight Nursing Service West Sussex
- Planned Treatment Centre (Crawley)
- Phlebotomy
- Tissue viability service
- Urgent treatment Centre (Crawley)
- Venous Leg Ulcer Clinic
Children and Specialist Services

- Audiology
- Infant feeding teams
- Community Paediatrics
- Child health information service
- Children’s continence service
- Children’s Physiotherapy
- Children’s Occupational Therapy
- Children’s Speech and Language Therapy
- Community children’s nursing and specialist nursing (West Sussex)
- Continuing care
- Family nurse partnerships
- Health visiting
- Looked after children
- School Nursing
- Sexual assault referral centre
- New-born Hearing Screening
- Health Improvement Team
- Specialist Health visiting
- Children’s Counselling service (Brighton & Hove)
- Chailey Heritage Clinical Services
- Specialist dental services
- Rehabilitation Services: inc: Sussex Rehab Centre, prosthetics, wheelchair services and community equipment
- Brighton and Hove Specialist palliative care services
- Midhurst Macmillan Specialist palliative care services
- Abdominal aortic aneurysm screening
- Carer health team
- Chlamydia Screening
- Cancer prevention Team
- Smoking Cessation B&H (school service only)
- Volunteers
- Contraception and sexual health services (CASH)
- HIV community specialist service team.
- Immunisation team
- Prevention Assessment team.
- Time to Talk
- Learning disabilities health facilitation team
- Expert Patient Programme
- Chronic fatigue Syndrome and ME Service
- MSK
- Physiotherapy
- Chronic pain service
- Radiology
- Rheumatology
- Podiatry & Orthotics
- Speech and Language Therapy
- Dietetics
Appendix 2

Quality Improvement Plan year 1 achievements

Key:

| Achieved: Green | In progress: Amber |

It is worth noting that for some actions have a two year implementation plan in place.

<table>
<thead>
<tr>
<th>Safe and Effective Domain</th>
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<tbody>
<tr>
<td><strong>Action</strong></td>
<td><strong>Achievement</strong></td>
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<tr>
<td>Development of pressure damage prevention strategy and reduction in pressure damage</td>
<td></td>
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<tr>
<td>Development and roll out of carers assessment for patient with pressure damage</td>
<td>Carers assessment developed and piloted Year 2 roll out</td>
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<tr>
<td>Reduction in medication errors</td>
<td>Part achievement – missed dose medications a priority going forward</td>
</tr>
<tr>
<td>For all in - patients to receive a Venous thrombo - embolism (VTE) assessment</td>
<td>Achieved during week days. Year two focus on weekends</td>
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<td>Improve advanced care planning for end of life care and develop an end of life care strategy</td>
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<tr>
<td>Develop a Dementia Strategy and Implementation Plan</td>
<td>Dementia assessment undertaken. Year two dementia strategy</td>
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<tr>
<td>Reduction in falls across In – patient units</td>
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<tr>
<td>Hand hygiene audits rolled out across community nursing services</td>
<td>In – patient audit tool has been adapted for community services. Year 2 roll out</td>
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<tr>
<td>To be No Never Events</td>
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<tr>
<td>Development of quality early warning trigger tool</td>
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<tr>
<td>Ensure safeguarding adults team in place and training rolled out</td>
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<th>Responsive and Caring Domain</th>
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<tr>
<td><strong>Action</strong></td>
<td><strong>Achievement</strong></td>
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<tr>
<td>Improve response times for complaints handling</td>
<td></td>
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<tr>
<td>Quality Walk rounds in place</td>
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<tr>
<td>Roll out of Friends and Family Test</td>
<td>Rolled out – remains a priority to increase uptake</td>
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<tr>
<td>Research and Development</td>
<td></td>
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<tr>
<td>Engagement and activity</td>
<td></td>
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<td>-------------------------------------------------------------</td>
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<tr>
<td>Audit of accessibility of services for patients with Learning Disabilities</td>
<td>Audit undertaken – improvements required are now a priority for next year</td>
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<tr>
<td>Develop care planning tool and review care plans</td>
<td>Now a priority going forward to ensure consistency of care planning and record keeping</td>
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<th>Well - Led Domain</th>
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<tbody>
<tr>
<td>Action</td>
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<tr>
<td>Develop staff competency framework</td>
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<tr>
<td>Doctors and dentists to have an annual appraisal</td>
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<tr>
<td>For all staff to have an appraisal</td>
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<tr>
<td>Undertake leadership training needs analysis</td>
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<tr>
<td>Implement safer staffing guidance and develop mitigation plans for safer staffing</td>
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