

Brighton & Hove Response to the NHS Long Term Plan
***Delivering the NHS response as part of our Joint
Health and Wellbeing Vision for our Population***

Paper for the Brighton & Hove Health and Wellbeing Board
November 2019

We have written a plan in Brighton & Hove to respond to the local health and care needs of our population and the ambition in the NHS Long Term Plan

WHAT IS THE BRIGHTON & HOVE PLAN?

1. In **Brighton & Hove** we have written a plan that represents our response to the **local health and care needs of our population** and the **national ambitions and expectations** set out in the **NHS Long Term Plan**.

2. The plan is a **joint contribution** from the key partners in health and care across Brighton & Hove:



Community &
Voluntary Sector



General
Practice



3. The Brighton & Hove plan sits alongside the **Sussex Strategic Delivery Plan**, which responds to the Sussex Population Health Check and covers aspects where the **highest quality care and outcomes for the population & patients** can be delivered through planning at a Sussex-wide level
4. We are meeting the needs of our local population and the national ambition of the NHS Long Term Plan in the local context of **growing demand for health and care** meaning services are under extreme pressure and people have to wait, **financial challenges**, a **workforce gap**, and existing **health inequalities**

The Brighton & Hove Response to the NHS Long Term Plan has been built on the foundations of the Brighton & Hove Joint Health and Wellbeing Strategy

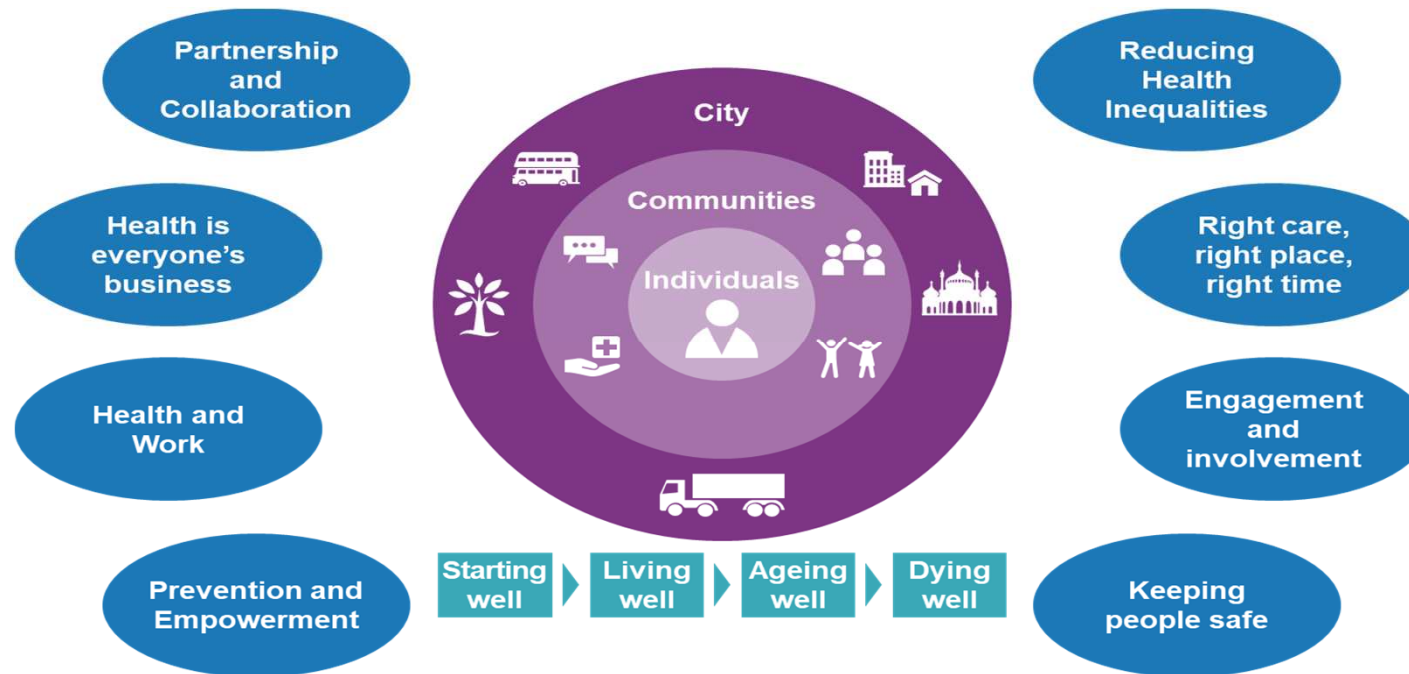
WHO HAS INPUTTED TO THE BRIGHTON & HOVE PLAN?

The Brighton & Hove response to the Long Term Plan supports **existing plans in the city** and:

- Builds on the **Joint Health and Wellbeing Strategy** as set out by the Health and Wellbeing Board
- Responds to local needs as identified in the **Joint Strategic Needs Assessment** carried out for the Health and Wellbeing Board
- Shows how **Brighton & Hove will deliver the local aspects** of the NHS Long Term Plan
- Responds to the needs of the local population as picked up in **extensive public engagement** involving **over 4,000 conversations with local Brighton and Hove residents** over the last two years
- Has been developed with the involvement of **partners, clinicians, health and care professionals, staff, and the public**

Our vision in Brighton & Hove is that everyone in Brighton & Hove will have the best opportunity to live a healthy, happy and fulfilling life

WHAT ARE THE BUILDING BLOCKS OF THE BRIGHTON & HOVE PLAN?



The Joint Health and Wellbeing Strategy is underpinned in the Brighton & Hove plan with our commitment to:

1. **Decentralised care and local delivery of health and care** to provide care that is **specifically tailored to the local needs of the local population**
2. **Care provided closer to home** where appropriate and support for people to **manage their own health and care**
3. **Joined-up care** that is focused on the **needs of the individual**
4. Role of the **voluntary sector** supporting our population and embedded throughout all stages of health and care
5. **Integrated physical and mental health care**

We are improving care in Brighton & Hove throughout the life course through a wide-ranging set of service changes, all supported by primary care

WHAT'S CHANGING IN BRIGHTON & HOVE? (1/3)

Start Well



- Supporting our young people with the transition to adult services in a way that increases independence and ties in with workplace and training support
- A multi-disciplinary approach to children and families tying together physical, mental health and community care
- Whole school approach to emotional health and wellbeing including enhanced Schools Wellbeing Service
- Pregnant women will have a designated clinician responsible for their care to provide continuity of care
- More children will have childhood immunisations
- Increased support for young people with autism and learning difficulties

Live Well – Personalisation



- Support to stop smoking, increase physical activity, maintain a healthy weight, improve nutrition, and drink less alcohol
- Personalised care approaches embedded in all interactions with health and care, supporting increased self-management of own health, empowerment to make decisions on own care in partnerships with clinicians, and personal health budgets for those with most complex care needs
- Faster access to physiotherapy for people with MSK conditions to support self-management
- Digitally-enabling primary care and outpatient care for a higher quality service that makes people don't have to travel to appointments if it's not necessary and are supported to self manage

Primary care provides services tailored to the specific needs of their local population, with an expanded workforce that can deliver care closer to home with fewer handovers of care for a seamless experience

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WHAT'S CHANGING IN BRIGHTON & HOVE? (2/3)

Live Well



- Improved outcomes from planned care in hospitals and shorter waiting times through improved diagnostic capacity, closer links between acute hospitals and GPs, evidence-based interventions, and less time spent in hospital when not clinically necessary
- Shorter waiting times in A&E through reducing pressure on emergency hospital services and an integrated network of community and hospital based care
- Greater support for population with COPD including mental health support and provision of pulmonary rehabilitation services
- Transgender population will have improved access to and experience of care
- The population has access to extended hours at GP practices
- More cancers will be diagnosed earlier
- Increased choice of location for operations if patients have been waiting for a long time
- Our university population will have increased mental health support
- The homeless in Brighton will have increased and improved support
- Those at risk of suicide will have a targeted support offer in partnership with the community and voluntary sector
- Those in need of an inpatient detox service for substance misuse will have access 24-hours 365-days a year

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WHAT'S CHANGING IN BRIGHTON & HOVE? (3/3)

Age Well

- Faster access to community crisis services (rehabilitation and reablement) will reduce unnecessary trips to hospital
- Continuing support for unpaid carers through Carers Hub, the joint app and increased identification of carers
- Supporting our ageing population to stay independent for longer through an Ageing Well signposting service to get the most from life in the city
- Enhanced support to people in care homes to support people to stay out of hospital
- Social prescribing and role of the community and voluntary sector in supporting our communities
- New dementia support services including Memory Assessment and Support service



Die Well

- Supporting more of our population to die in their place of residence
- Advanced care planning to meet preferences at the end of life
- More coordinated planning for end of life care involving the voluntary and community sector



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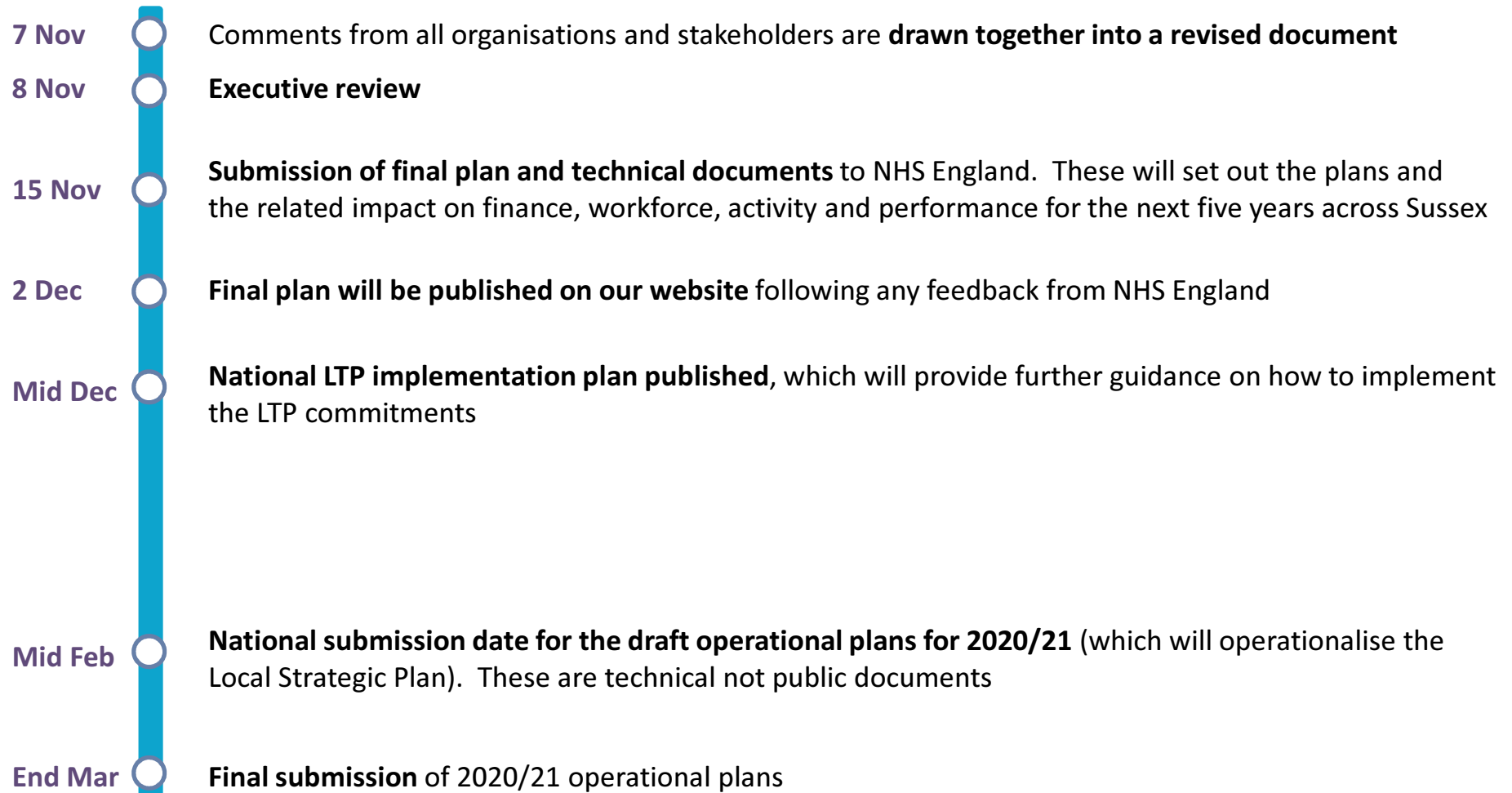
Closer working together in Brighton & Hove is needed to provide tailored and high quality provision of health and care to our local population

WHAT ARE THE KEY RELATIONSHIPS IN BRIGHTON & HOVE?

1. **Working together** as organisations supports the patients and wider population to have a **seamless experience of health and care** where the most **appropriate care is provided quickly**, moving away from **fragmented care** where the focus is on treating episodes of ill health rather than the cause of illness or preventing illness in the first place.
2. We will be changing **how organisations work** to allow health and care provision to be most appropriately tailored to local needs:
 - Sussex is working towards becoming an **Integrated Care System**, a partnership of health and care organisations working together to provide overall assurance for the Sussex health and care system, provide a forum for strategic oversight, facilitate collaboration and joint planning on enabling functions including workforce, digital and estates, and plan and commission specialist services where there are clinical benefits to this being done at a Sussex level.
 - Our **Integrated Care Partnership** will be an alliances of health and care organisations working together to plan and provide services for the population in a consistent and joined-up way. They **will not** be new organisations and **will not** change the accountability of current providers or their statutory duties.
 - Our seven **Primary Care Networks** are groups of GP practices collaborating with local community services, mental health, social care, pharmacy and voluntary sector teams to provide integrated local health and care for communities – building on the ongoing work in “Cluster 6” which has worked closely with the voluntary sector.

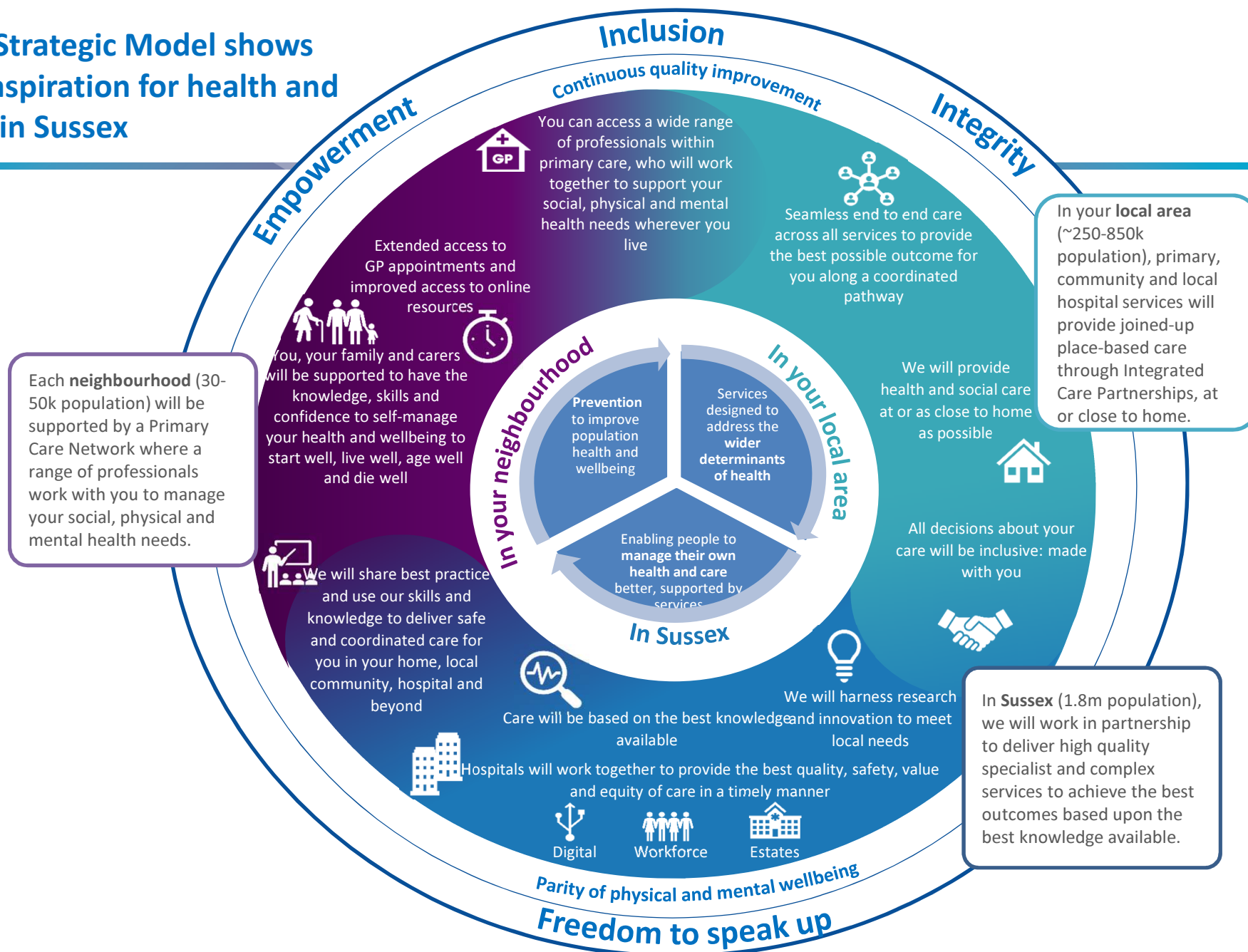
The next steps are to incorporate feedback into the revised plan, submit to NHS England and develop operational plans for 2020/2021

WHAT HAPPENS NEXT?



APPENDIX

Our Strategic Model shows our aspiration for health and care in Sussex



The Health and Care Strategic Plan has been developed by the Clinical and Professional Cabinet to describe the future of health and care in Sussex

SUMMARY OF HEALTH AND CARE STRATEGIC PLAN INTENT

- The Health and Care Strategic Plan has been written to **respond to areas of concern raised by the Population Health Check**:
 - **Demand for health and care services is rising**, with more people living with multiple long term conditions
 - We have the **opportunity to integrate services** and provide a **coordinated end to end pathway**
 - We have an **engaged population who want to be actively involved in their care**
- The strategy aims to:
 - Strengthen the **role of prevention and address the wider determinants of health**
 - Support people to have the knowledge, skills and confidence to **self-manage and protect their own health**
 - Address the need for **responsive and flexible services, supported by technology**
 - Address the growing number of **people with long term conditions**
 - Improve **access to urgent care**
 - Maximise the benefits from **specialist services**
- The bedrock of the model is close and effective working between primary and urgent care, community and mental health services, social care and the voluntary sector:
 - Primary Care Networks will lead the integration of care and promotion of quality and safety
 - Integrated Care Partnerships will use data to plan services for the benefit of the population
 - The population will identify outcomes that matter to them, to inform the development of Integrated Care Teams
 - We will re-define our clinical, professional, operational, and financial accountabilities to reflect the scope of Integrated Care Teams
 - Our financial framework must gradually increase the proportion of total resource spent on primary and community care without undermining performance in the acute setting
- Health commissioners will collaborate with local authority commissioners on the delivery of health and care, and on a programme to address current inequalities