Brighton & Hove – Place-Based Response to the Long Term Plan

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

October 2019

Revised Draft

Working in partnership across Sussex

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1. Purpose of our plan

The purpose of this plan is to describe our collective vision for the Brighton & Hove system and outline how by working together we can achieve the commitments set out in the Long Term Plan and NHS Long Term Plan Implementation Framework. The partners in health and care in Brighton & Hove (Brighton & Hove Clinical Commissioning Group, Brighton and Sussex University Hospital Trust, Brighton & Hove City Council, Sussex Community Foundation Trust, Sussex Partnership Foundation Trust, Community Roots, General Practice, patients and the public) are committed to working together to drive improvements in the health and wellbeing of the population we serve. The strength of our cooperative relationships reflects the growing emphasis of joint working and integration across boundaries with Brighton & Hove City Council, NHS organisations and community and voluntary organisations in the city.

This plan sits alongside our local Brighton & Hove Joint Health and Wellbeing Strategy, reflecting the prevention agenda necessary to support the health of our population over a life course, and address our local population health and care needs as identified in the Joint Strategic Needs Assessments. The Brighton & Hove Response to the NHS Long Term Plan should also be read alongside the Sussex Health and Care Partnership Strategic Delivery Plan.

Our approach to developing this plan is to articulate the actions we will take to support improvements throughout the four stages of life, namely Starting Well, Living Well, Ageing Well and Dying Well. The plan considers:

- The needs of our whole Brighton & Hove population (residents, workers and visitors) and the outcomes required to meet them, as defined in our 2019-2030 Joint Health and Wellbeing Strategy;
- The NHS finance and activity modelling across the next five year period;
- Our plans for driving the transformation and integration required to meet population health and care needs, reduce health inequalities and deliver longer- term sustainability.

2. Where we are today

2.1 Our population

There are currently 290,400 people living in Brighton & Hove including significant populations from LGBTQ+, BAME, traveller and homeless communities. The city has a more diverse, mobile, younger population profile than England, contributed to by a high university student population. In the context of a young but ageing population, there are considerable health inequalities, falling healthy life expectancy, and health outcomes across the life course considerably lower than we would like them to be. There are citywide factors that also impact on the health of our population, both negatively and positively.

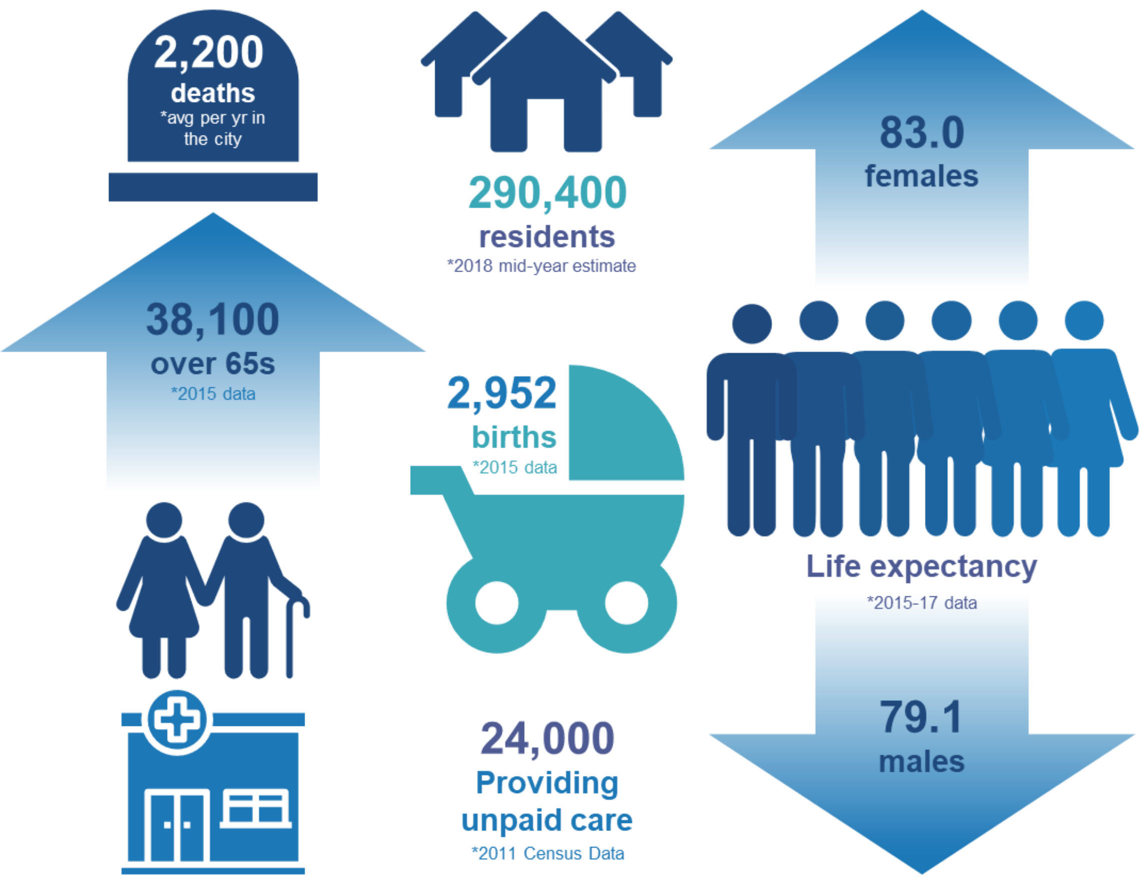


Figure 1: Our population

The shape of Brighton & Hove's population is due to change. The population is predicted to increase at a faster rate than the South East and England by 2030 (by 23,300 people or 8%). The age profile is also predicted to get older by 2030, with 30% more people aged 75 or older (5,300 people) compared with 2017. The number of children and young people will increase slightly by 2030, with an increase of 6% children aged 0-4 and 10% young people aged 15-24.

Life expectancy in Brighton & Hove was 83.0 for women and 79.1 for men in 2015-17. Having increased over recent decades, data suggests that this trend may have stalled in the last five years (in line with national trends in life expectancy, which began to plateau in 2010). Healthy life expectancy, however, has fallen, meaning that on average a larger proportion of life spent in poor health, increasingly with multiple long term health conditions. In Brighton & Hove women can expect to live 25% of their life in poor health (23% in England), while males in Brighton & Hove can expect 22% of their life to be lived in poor

health (20% in England). In addition, there are significant health inequalities across our population, including a gap in life expectancy of ten years in men and six years in women between the most and least disadvantaged areas in the city.

2.2 The bigger picture and wider determinants of health

Our strategy recognises the wider determinants of health and seeks to support prevention, tackle health inequalities and establish a population health management approach to underpin the new model of care set out by the Long Term Plan.

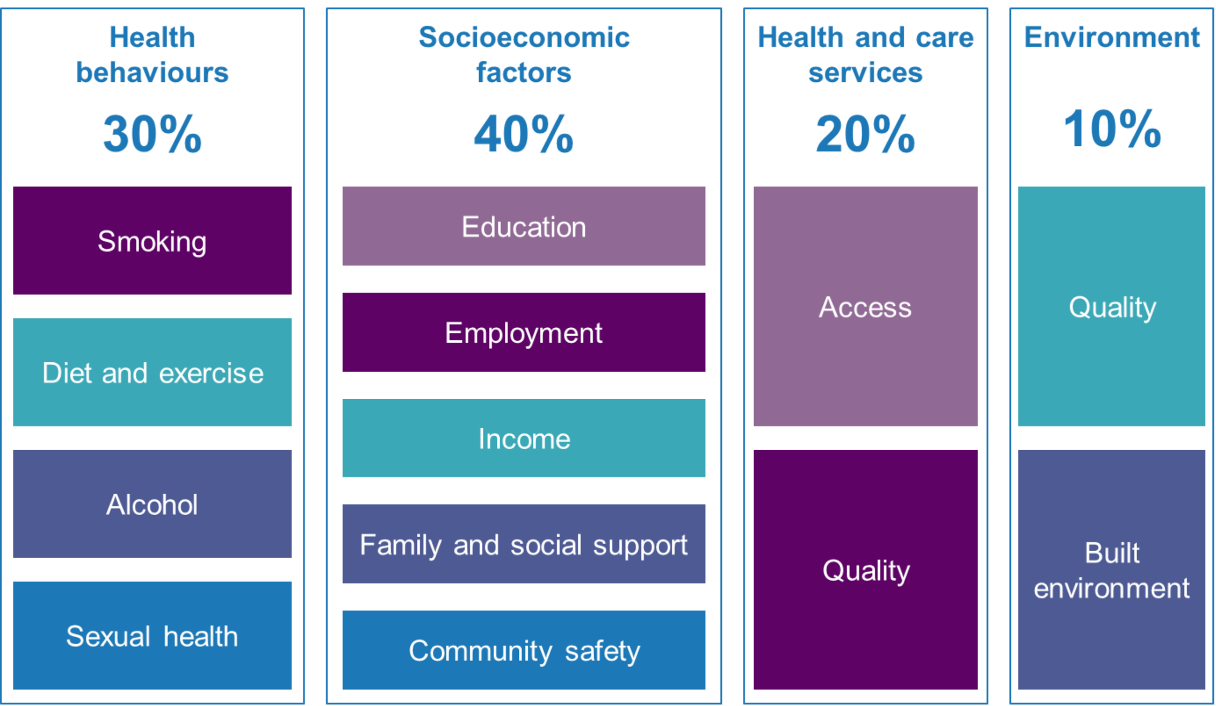
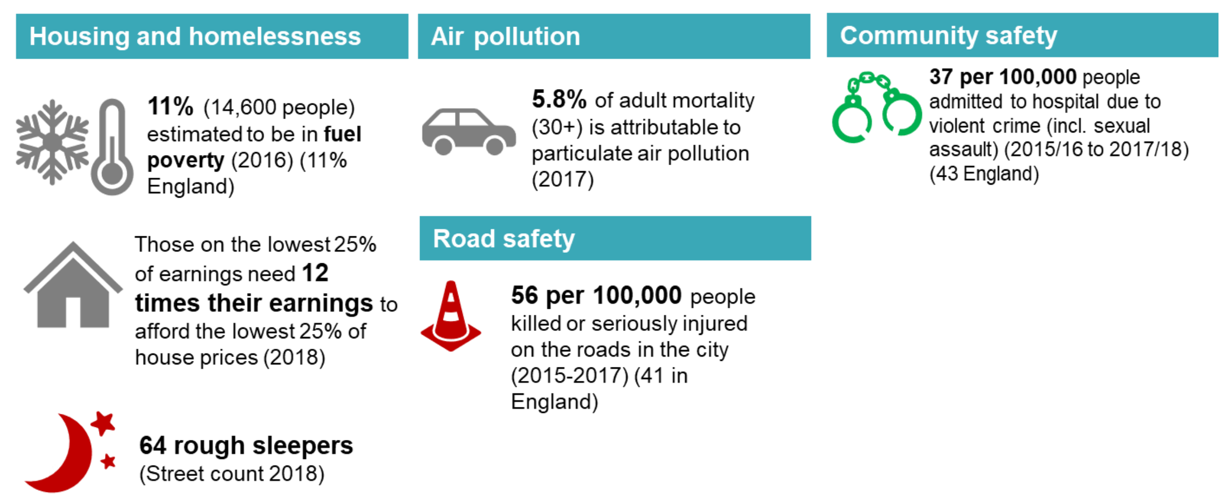


Figure 2: Wider determinants of health; Source: County Health Rankings Model 2014

Our plan recognises that the following key citywide factors impact significantly upon health and wellbeing outcomes:



Local data (from our Joint Strategy Needs Assessment July 2019) highlights relatively good health and wellbeing in younger children but less good health and wellbeing for our young people:

- Significantly better than England
- Not significantly different to England
- Significantly worse than England
- Significantly higher than England
- Significance cannot be calculated

Children in care

77 per 10,000 children and young people in care (Sept 2018 Brighton & Hove, March 2018 England)

Child poverty

16% of children live in poverty (17% England 2016)

Youth unemployment

4.5% 16-17 year olds not in education, employment or training (6% England 2017)

School readiness

72% achieving a good level of development at end of reception (72% England – 2018/19)

Disabilities and sensory impairments

There are **almost 2,000** children and young people with a disability or impairment on the local register

It is estimated that there are up to **600** children and young people with Autistic Spectrum Conditions

Education

Educational progress pupils make between primary and secondary schools is in line with England average (2017/18)

Healthy weight

81% of 4-5 year olds are a healthy weight (2017/18)

73% of 10-11 year olds are a healthy weight (2017/18)

However, it is estimated that **14,000** children and young people in the city are **overweight or obese**

Maternal & infant health

88% breastfeeding by 48 hours 75% England (2016/17)

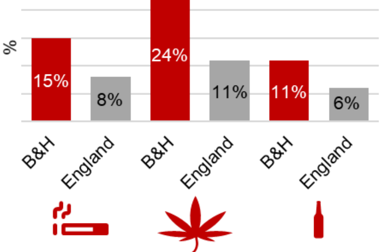
6% smoking at delivery 11% England (2017/18)

Most childhood immunisations, including MMR at five years (2017/18), are **below the 95% required for population protection**

Under 18 conceptions **19 per 1,000** (2017) (18 England)

Young people

We have the highest % of 15 yr olds who smoke, have tried cannabis and the 3rd highest drinking weekly in England (2015) and high Sexually Transmitted Infection (STI) rates in young people



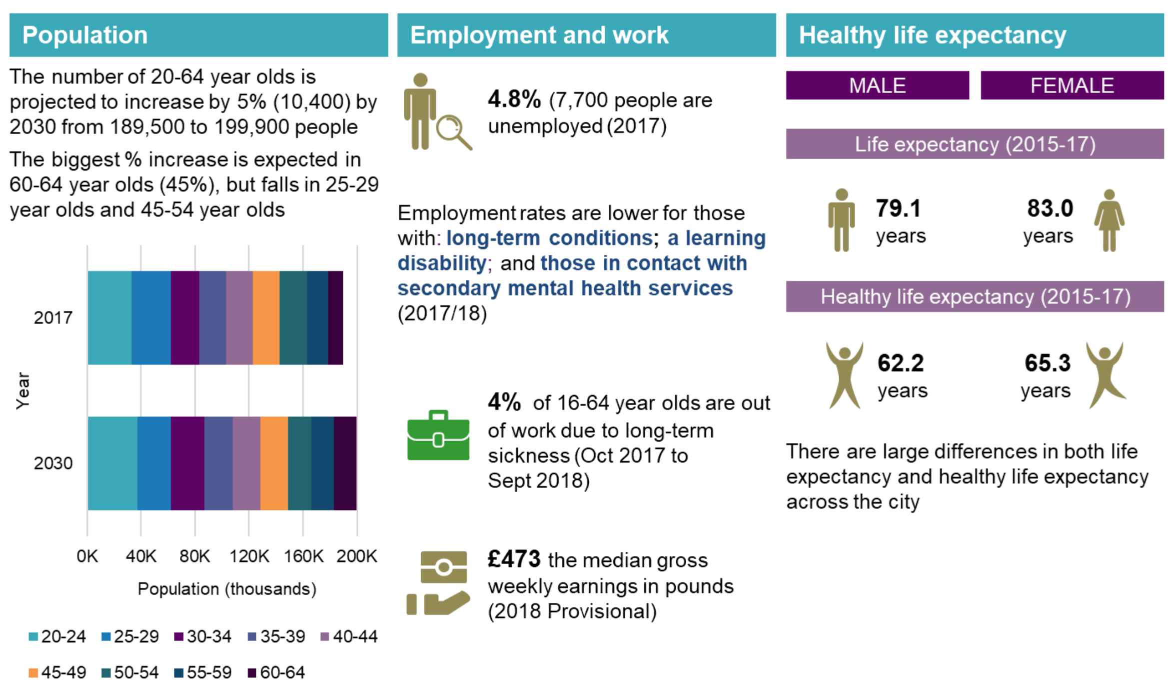
Emotional wellbeing

549 per 100,000 10-24 yr olds admitted to hospital for self-harm (2017/18) (421 England)

17% of 14-16 yr olds say they often / sometimes have suicidal thoughts and

10% say that they often / sometimes hurt or harm themselves (2018)

For our adult population there are several health outcomes that are poorer than expected, alongside several health outcomes that are better than the England average:



Lifestyles

19% of adults are current smokers (2018)

697 per 100,000 people had alcohol specific hospital admissions in 2017/18

10.6 adults per 1,000 aged 15-64 estimated to use opiates and/or crack cocaine (2014/15)

We have the highest rates of new STI diagnosis and HIV prevalence (2017) outside of London

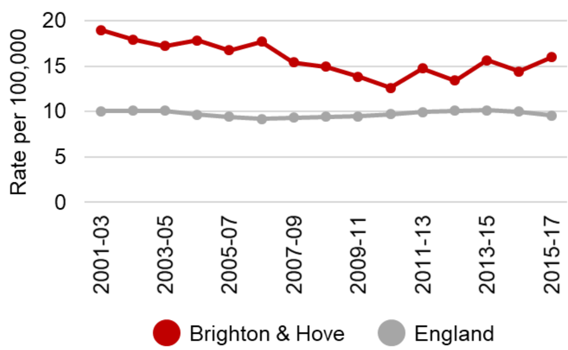
77% of adults are physically active and 16% inactive (2017/18)

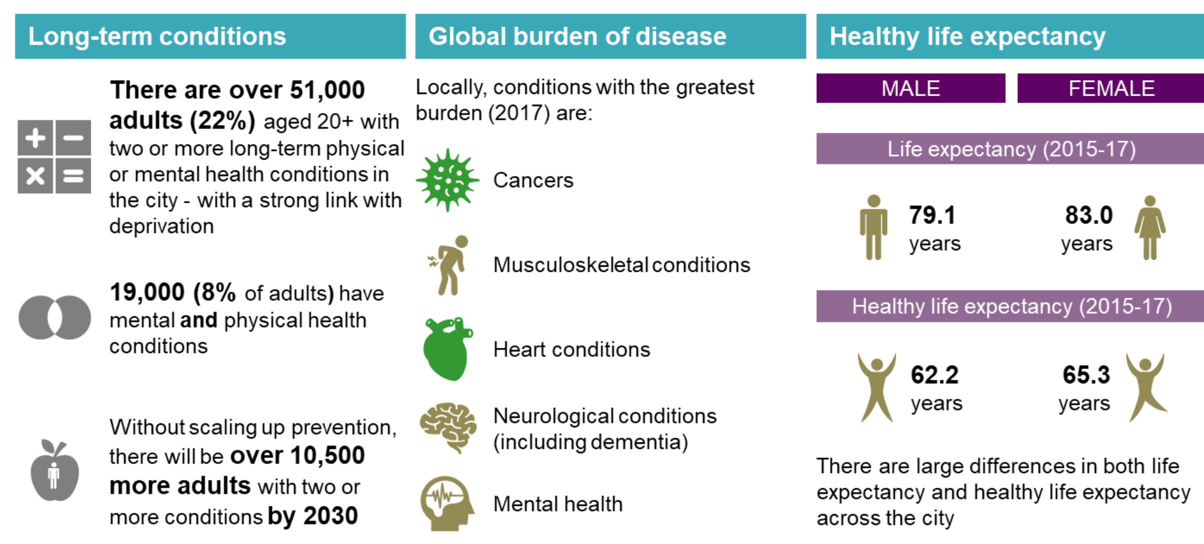
14% of adults cycle to work at lease once a week (2017)

Emotional health

10% of adults are on GP practice depression registers and 1.2% severe mental illness (2017/18)

16 per 100,000 suicide & undetermined injury deaths (2015-17), the highest rate since 2006-08 and 2nd highest in England

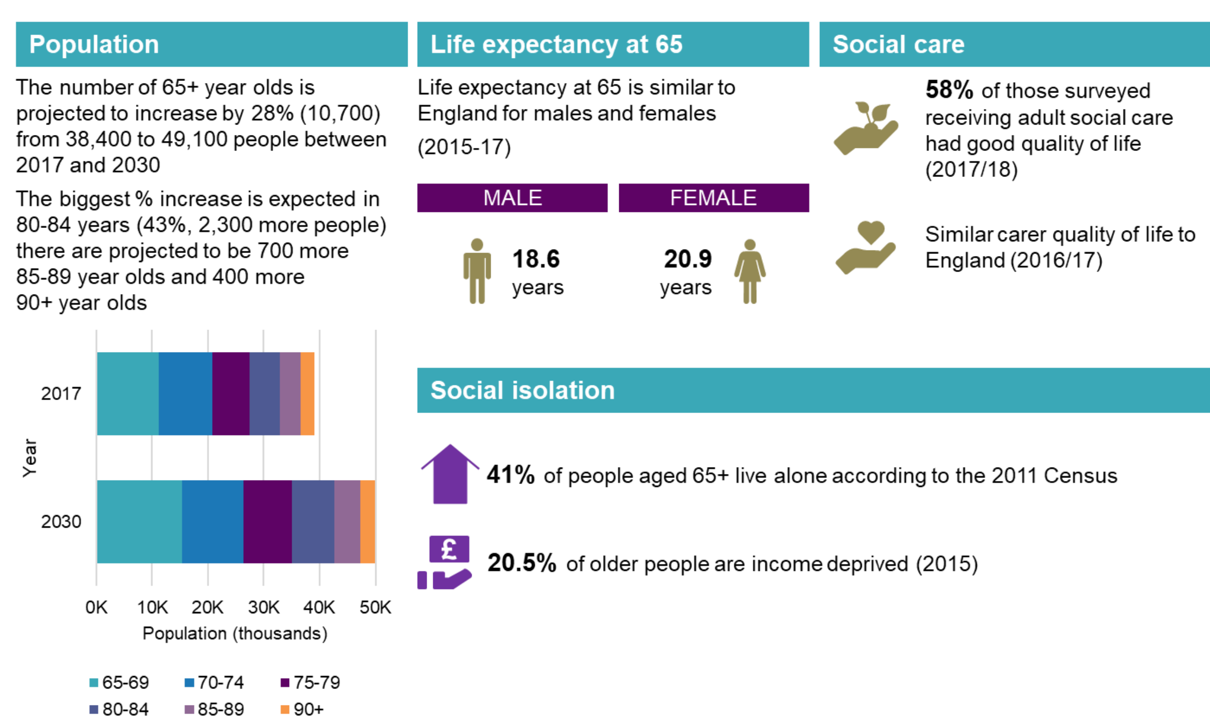




Cancer screening

Screening rates for breast, cervical and bowel cancer are all lower than England

Health outcomes for the elderly tend to be in line with the England average or worse than the England average, although Brighton & Hove do better than the England average in place of death:



Dementia and sight loss

4.6% of 65+ yr olds have a record of dementia (2018)

104 in every 100,000 65+ year olds have age-related macular degeneration (preventable sight loss) (2017/18)

Falls and hip fractures

2,465 per 100,000 people aged 65+ were admitted as an emergency to hospital due to a fall (2017/18)

and **552 per 100,000** people aged 65+ had a hip fracture (2017/18)

Flu immunisation

Flu immunisation uptake at **67.5%** in 65+ year olds (2017/18) is below the goal of 75% (England 73%)

Place of death

The majority of people would prefer to die at home. In **half of all deaths (51%)**, the place of death is the place of usual residence (2017)

This is above England and has increased from 40% in 2006

There were **31% more deaths of 85+ year olds in winter** in the three year period August 2014 to July 2017 than would be expected if the rates were the same as non-winter months

2.3 Our current health and care provision

The majority of the health and care services in our local system are rated by the Care Quality Commission (CQC) as 'good' or 'outstanding'. A summary of the ratings for the services provided in the city is as follows:

- Brighton and Sussex University Hospitals NHS Trust (BSUH) has an overall rating of 'good' and 'outstanding' for caring;
- Sussex Partnership NHS Foundation Trust (SPFT) has an overall rating of 'good' and 'outstanding' for caring;
- Sussex Community NHS Foundation Trust (SCFT) has an overall rating of 'good';
- Brighton & Hove CCG has an overall rating of 'good';
- Homeless Primary Care Service rated as 'outstanding';
- 91% of adult social care providers with a 'good' or 'outstanding' CQC rating, which is well above the national average of 83%.

2.3.1 Brighton & Sussex University Hospitals NHS Trust

Brighton & Sussex University Hospitals NHS Trust has been rated 'good' overall following a CQC inspection in September 2018. The Trust was rated 'good' in the safe, effective and well-led domains, 'outstanding' in caring and 'requires improvement' in the responsive domain. This is a significant improvement as the Trust has been in special measures for quality since 2016.

The inspection noted that the Trust had a new strategy, vision and values which underpinned a culture which was patient centred. Quality was a 'golden thread' running through the strategy. Staff felt respected, supported and valued, equality and diversity were promoted in the workplace. The areas which required improvement were Urgent and Emergency services, end of life care and outpatients across both Royal Sussex County Hospital (RSCH) and Princess Royal Hospital (PRH) sites. Themes included access to services, referral to treatment times, psychological support for patients and discharge process. These areas have been identified as priorities for improvements in the BSUH Quality account 19/20.

2.3.2 Sussex Community NHS Foundation Trust

Sussex Community NHS Foundation Trust (SCFT) has been rated as 'good' overall following a CQC inspection in 2017. The CQC's overall rating of the Trust had not changed. Ratings across all CQC domains are now 'good' and two areas were rated as 'Outstanding' – caring in community inpatient services and responsive in community end of life care. Areas identified for improvement included management and quality of medical records, referrals to mental health services, the monitoring and administration of pain relief and consistent advice on how to complain throughout all locations.

2.3.3 Sussex Partnership NHS Foundation Trust

Sussex Partnership NHS Foundation Trust (SPFT) has been rated as 'good' overall with 'outstanding' in the caring domain following a CQC inspection in 2019. Mental health crisis services and health-based places of safety were identified as 'requires improvement' alongside working age acute wards and psychiatric intensive care units. These areas have been identified as priorities for improvements in the SPFT Quality account 19/20. The NHS Long Term Plan includes the NHS Mental Health Implementation Plan 2019/20 – 2023/24 with a focus on improving the mental health crisis response nationwide.

2.3.4 South East Coast Ambulance Service

The CQC inspected the South East Coast Ambulance Service (SECAmb) in 2019 and has rated the Trust as 'good' in all domains with an overall rating of 'good'. SECAmb emergency and urgent care services were rated as 'outstanding' in the caring and well lead domain with an overall rating of 'outstanding'. The 111 service was rated as 'good' overall. It was rated as 'good' for safe, caring, responsive, well-led and requires improvement for effective.

Despite the system's positive ratings one area that has been particularly challenging has been in urgent care and specifically the performance of the Emergency Departments (A&E) at Brighton and Sussex University Hospitals NHS Trust (BSUH). An increase in the number of people using the departments has meant patients have had to wait longer than we would have liked to be seen, treated, and either admitted or discharged. We have worked hard with all local health and social care organisations to ensure the safety and quality of services was maintained and several initiatives and improvements have been introduced. These aim to reduce the number of people going to A&E for treatment and make it easier for patients to leave hospital when they are ready, which frees up space for other patients who need hospital care. Section 4.2.7 sets out our plans to improve urgent care.

Another area we need to improve is the performance against the waiting times from GP referral to when the patient is treated. The national target is 18 weeks, and this has not been achieved locally for several years. Waiting lists have developed and we are working very hard with BSUH and other hospitals to reduce these. We have paid for patients to be treated at other hospitals and providers to speed up their treatment, but we recognise there is still work to do in this area. Section 4.2.2 sets out our plans to improve planned care.

We also need to focus on improving some areas of performance for local cancer patients. There have been circumstances where some patients have had to wait longer than they should for diagnosis and treatment, particularly those being referred urgently for their first treatment. This is something we are working with providers to improve as our priority is to ensure all cancer patients receive the care they need in the quickest possible way. Section 4.2.7 sets out our plans to improve cancer care.

3. Our approach in Brighton & Hove

Demand for our health and care services is rising due to several factors, including both our growing and ageing population. The success of promoting longer life creates pressures on health and care services as more people live for longer with one or more long term conditions. We are looking to meet this demand through a life course approach focusing on prevention and the wider determinants of health, a clear set of system priorities, and a system reform journey towards integrated services. We have set out the governance and the roadmap to do this.

3.1 Our health and wellbeing vision

We aspire to deliver improved population health through proactive population health care management, making our already good care, excellent, and working together as partners to improve the health and wellbeing of the population and deliver better value for money.

Our Joint Brighton & Hove Health and Wellbeing Strategy 2019-2030 vision for the city is that *everyone in Brighton & Hove will have the best opportunity to live a healthy, happy and fulfilling life.*

This strategy has been developed jointly with our health and population experts, clinicians, provider partners and our population, as well as being based upon detailed population analysis. It seeks to improve the health and life experience of everyone within our local population across their whole life, addressing the specific health needs within Brighton & Hove and focusing on prevention, the wider determinants of health, and actively reducing health inequalities. The strategy describes the 'four wells' vision of health and wellbeing in the city; Starting well; Living well; Ageing well; and Dying well.

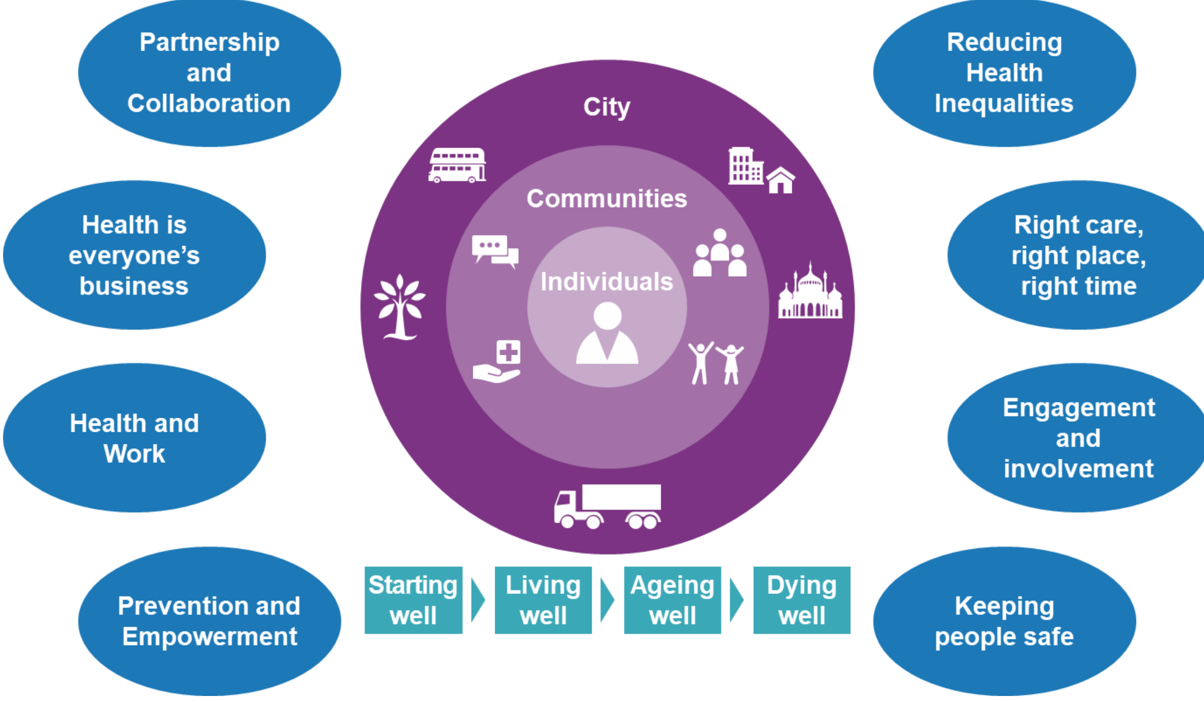


Figure 3: Our Health and Wellbeing Vision

3.2 Our system priorities

Within our 'four wells', we will work collaboratively on the following system priorities:

- Prioritising prevention across the system, enabling people to self-care and self-manage as much as possible and tailoring our engagement methods to ensure we reach the harder to engage groups within our population. We will ensure social prescribing is embedded throughout the life course.
- Supporting the development of Primary Care Networks (PCNs).
- Improving mental health and wellbeing.
- Meeting the new funding guarantees for primary medical and community health services.
- Community health responsiveness.
- Implementation of universal model for personalised care.
- Improving planned care (including cancer care and outcomes) and reducing waiting times.
- Reducing pressure on emergency hospital services.
- Continuing support for the role of carers.
- Digitally-enabling primary care and outpatient care.

3.3 Our approaches to underpin our collaborative system

The findings from the Joint Strategic Needs Assessment, additional population data analyses, and engagement feedback, were brought together in a series of workshops to inform a set of approaches to be adopted as we move into our new collaborative system and deliver our plans:

- We will use data and intelligence in an open and transparent way with our population, developing and using the Sussex Integrated Dataset, Joint Strategic Needs Assessments, Primary Care Network Profiles and Right Care Data to drive service change.
- We will make integrated physical and mental health services a matter of principle in all our future commissioned models of care. This will include a new approach to mental health training for all professionals working in our services.
- We will give further focus to whole-life, children and families rather than separating paediatric and adult services.
- We will set a clear aspiration to how we can sustain continuity of care for patients who need to see the same clinician in the community, within the workforce limitations we are dealing with.
- We will standardise our definition of deprivation, find an appropriate language to use with our local communities and introduce the practice of commissioning proportionate universalism in order to reduce health inequalities. This will see more use of an assets-based approach to improve health and wellbeing and will enable resources to be equitably allocated to address inequalities in access and health outcomes. We will monitor key indicators for health inequalities, increase monitoring of protected characteristics and developing a programme of health equity audits across health and care commissioned services in Brighton & Hove to track and build on progress.
- We will commission for our population and population health rather than for individual organisations.
- We will re-invigorate our relationship with communities and community leaders and establish meaningful forums to enable co-production and an asset-based approach to delivering services.

Our Target Operating Model focuses on asset-based approaches, prevention, early intervention and reablement, seeking to ensure people realise their full potential before long term care decision are made, adopting the following approaches:

- Outcome focused interventions and contribution to wider system outcomes.
- Building personal and community resilience to support people to access their own strengths and link with their communities.
- A joined-up approach to delaying, reducing and preventing care needs working with Primary Care Networks, NHS community providers, and the community and voluntary sector.
- Communicating in a common language between care settings.
- Using linked social, wider council and health data to understand and respond to the needs of the population.
- Optimising community support to recognise those at risk of deterioration, communicate this to relevant system partners and act early to prevent deterioration and unnecessary admission to hospital and care homes.
- Ensuring that people receive appropriate and timely support after a hospital stay to prevent deterioration and over-prescription of care, including Discharge to Assess pathways, embedding learning from other regional models, and optimising interim support placements to prevent exacerbations.

As a system, we agree that integration is strongest and most effective when collaborating at place to integrate physical and mental health across all patient pathways bringing in elements of social prescribing and the role of the voluntary sector across the entire pathway, with the voice of the public and patients fully involved in co-production, co-design and co-delivery.

3.4 System transformation through integration

To meet our health and wellbeing vision, address our system priorities, and action our approaches to collaborative working, we need to work together more closely as a Brighton & Hove system. Historically, health and care services across primary care, community, mental health, social care, acute services and voluntary and community sector have developed in relative isolation, and this has created barriers for our population. It is now widely recognised that a successful and effective health and care system is better built on foundations of integration across systems, organisations and people. Our approach will support the delivery of more streamlined services, delivering shared goals and better utilising financial, workforce and estate resources. This will deliver a transformed health and care system better equipped to meet the challenges of 21st century population utilising our local assets, technology and clinical advancements to our best advantage. We now have the opportunity to plan better to integrate these services and provide a coordinated pathway for local people across health and social care.

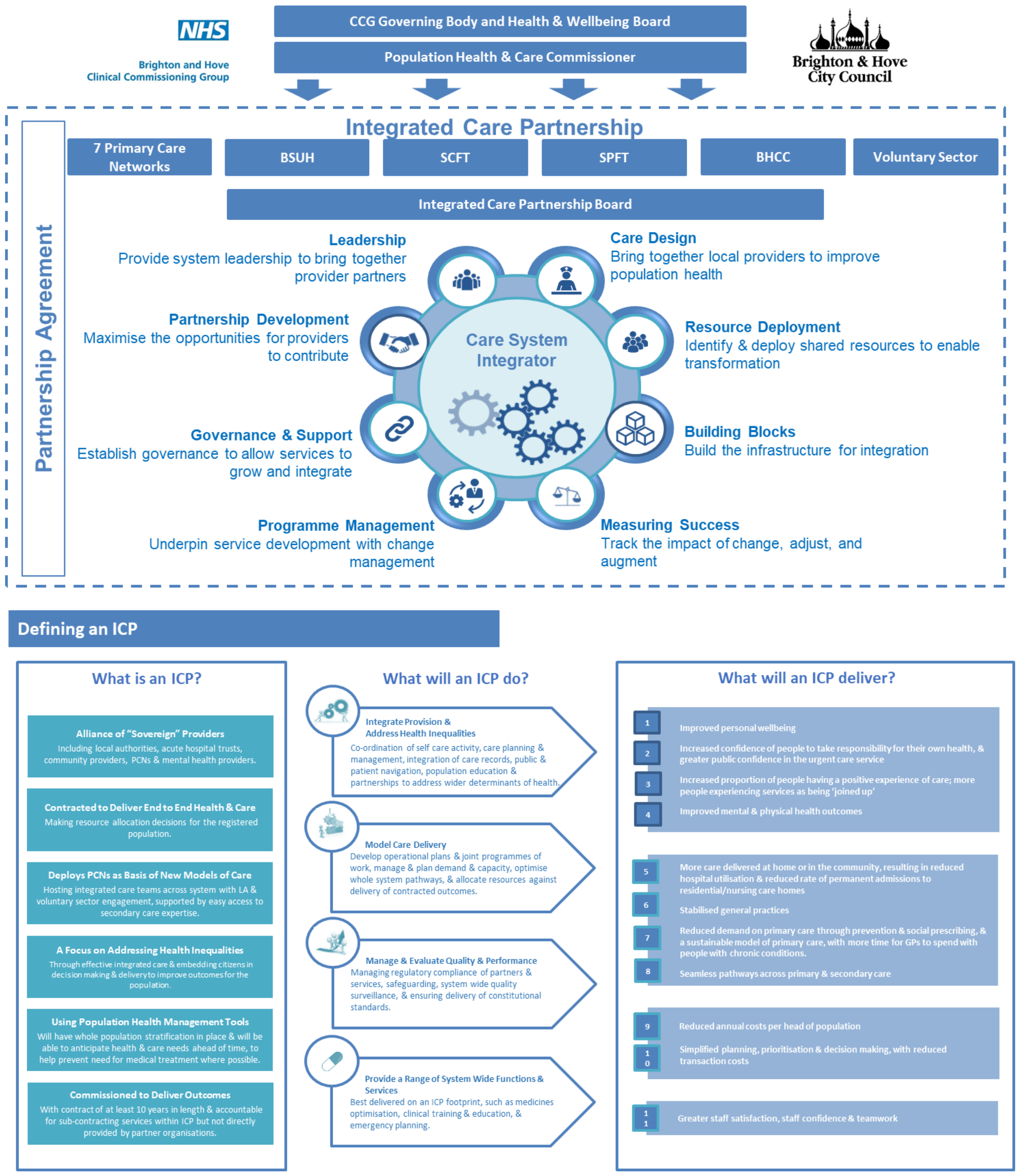


Figure 3: Defining an ICP

An Integrated Care Partnership (ICP) is the enabler to allow us as a system to manage the health of our population and drive the transformational change needed to achieve better outcomes. By developing new service models together, health and social care services can be aligned much more effectively around the holistic needs of individuals, and many of the historic barriers between services and providers which have hampered care planning and delivery can be addressed. Joint commissioning will give greater emphasis to prevention, early intervention, and tackling the wider determinants of health including socio-economic status, educational levels, employment, housing, diet and other lifestyle risk factors which have a significant impact on the health and wellbeing. Brighton & Hove City Council and the CCG in Brighton & Hove already have a good track record of working collaboratively and the development of an ICP and the opportunities this will bring will build upon this foundation for the benefit of the local population.

Key commitment areas for our local Integrated Care System are outlined above in section 3.2 – our system priorities.

The above commitment areas are not withstanding the need to also ensure system partners are working together to address the wider determinants of health including socio-economic status, educational levels, employment, housing, diet and other lifestyle risk factors which have a significant impact on the health and wellbeing.

To deliver integrated care in Brighton & Hove, collaboration between providers and commissioners is required. For our model to be successful, all organisations must be financially sustainable and our financial framework must gradually increase the proportion of total resource spent on primary, community and preventative care without undermining performance in the acute setting.

3.4.1 Primary Care Networks

A key element of collaborative and integrated working as set out in the NHS Long Term Plan are Primary Care Networks. Brighton & Hove has 35 General Practices, which have now formed seven Primary Care Networks (PCNs), each constituting a combined list size of 31,000 to 62,000 patients. They had previously been grouped into six clusters.

A pilot scheme which began in autumn 2018 will inform the development of PCNs in Brighton & Hove. GP practices in Cluster 6 (now the Goldstone PCN) and key partners, including the CCG and Brighton & Hove City Council Health and Adult Social Care Directorate including public health, and Sussex Community Foundation Trust came together with the aim of facilitating better joint working in order to address system-wide challenges using an evidence-based approach.

A steering group was established to deliver the following objectives:

- To design a model of integrated working at cluster level that integrates primary, community, mental health, social care, healthy lifestyles, voluntary sector and secondary care where possible and pilot in the Goldstone PCN;
- To work within the overall strategies of the constituent organisations;
- To seek feedback from operational staff working at cluster level on operational practical challenges;
- To agree solutions to these as part of developing a new model of integrated care.

A working group is driving the development of the model, seeking to test the model of integrated working at cluster level that integrates primary, community, mental health, social care, healthy lifestyles, voluntary sector and secondary care using feedback from operational staff and escalating issues/barriers to the steering group.

An insight into integration within the Goldstone PCN…

"Since 2018/19, Cluster 6 (now Goldstone PCN) has worked closely with the voluntary sector as part of the multi-disciplinary team working pilot. Organisations involved have included the Carers' Centre, Together Co and Community Roots. There are also two patient representatives involved in the work programme who help shape the way of working together."

Gemma Clayton, Senior Manager of Community Services Commissioning, October 2019

3.4.2 Enablers to integration - data

Data and information is a key enabler to collaborative working across PCNs and ICPs. Brighton & Hove ICP partners will use the data to better understand population needs and assets in order to improve design and delivery of services. Fundamental to this will be the use of linked data across health and care providers using integrated health and care records.

The Goldstone PCN is also piloting as part of the Local Health and Care Records (LHCR) the Sussex Integrated Dataset (SID). The SID is a way of connecting health and care data across NHS, social care and other organisations to ensure services are better able to improve people's health and wellbeing. The SID involves linking of patient level data from across the NHS, social care and other organisations that is routinely collected. The Brighton & Hove ICP and PCNs will be able to use the SID to segment their population and better co-design health and care services with people.

3.4.3 Enablers to integration – clinical shadowing

To support integration between primary and secondary care, local system leaders are facilitating a series of workshops to jointly work through shared issues, and participation in a buddy system where acute and community clinicians can spend time learning in each other's job roles. The voluntary sector has expressed interest in exploring clinical shadowing of job roles in the voluntary and community sector to build understanding across the system.

The initial five priorities for discussion and work are:

- Timely two-way semi-urgent communication between primary and secondary care;
- Role of secondary care clinicians in arranging onward referral;
- Ordering of investigations and responsibility for acting on the results;
- Secondary care doctors prescribing urgent medication when patients leave hospital or clinic;
- Secondary and emergency care referral for "two week wait" process and communication with patients about what this means for them.

"We are committed to improving how colleagues across the system work more closely together to improve communication, thereby facilitating high quality patient care and reducing daily frustrations with the aim of improving workforce moral and retention.

Learning from work in Wessex, a 'GP-Consultant' exchange scheme was established with matched pairs of GPs and BSUH Consultants spending a half day shadowing each other, to increase understanding of respective roles, frustrations and dilemmas.

80 clinicians participated with a follow up 'celebration' event. Verbal and written feedback was very positive, and we are confident that this will be translated into improved communication as an important basis for developing the system. Future exchange schemes are planned, including as part of inductions for new staff."

Dr David Supple, CCG Clinical Chair and Dr Rob Haigh, BSUH Medical Director, October 2019

3.5 Our governance model, programme leadership and resourcing

Brighton & Hove has set out a clear trajectory to closer system working, on the journey to becoming an ICP. There is a strong history of partnership working between the CCG and the City Council, with the next steps on the journey to build strong partnership between all partners in the system.

There is a strong history of partnership working between the CCG and the City Council:

- The £30m Better Care Fund, now in its seventh year, has supported delivery of an 8% reduction in DTOCs since 2017;
- S75 and S117 mental health agreements result in productive workflow practices and it is now exceptionally rare, if ever, that care is delayed due to a funding dispute;
- The CCG and City Council have a long-established Children and young people's Commissioning Programme and are taking a partnership approach to older people's care through the Ageing Well Programme;
- In 2017 a joint transformation programme, Caring Together, was established to enable the development of a set of system health and care priorities, and included a public engagement programme "The Big Health and Care Conversation" which became the exemplar engagement for the Sussex Health and Care Partnership engagement programme;
- The Health and Wellbeing Board has approved a period of "shadow" integration, providing the opportunity to undergo a programme of population health strategy, governance and finance review seeking to align annual budget-setting processes;
- The Joint Health and Wellbeing Strategy was published in 2019 to provide the direction until 2030;
- A CCG 5-year budget and indicative savings forecast has been developed, and CFO discussions have indicated savings expectations on investments into the City Council for 2019 and 2020, which will provide a more predictable landscape on which to agree new joint investments into programmes such as Prevention.

In our current state we are preparing to have greater system working:

- Local health and care leaders have visited Manchester Devo, and have run partnership workshops exploring future ways of working through integration;
- All system partners have undertaken the NHSI Transforming Care through System Leadership course;
- The Health and Wellbeing Board has agreed to undertake a review of its membership, scheduled for completion by January 2020, with the intent to invite a broader organisational membership to facilitate closer collaboration.

We aspire to have a future governance model that allows us to provide the best possible care to our population, and aspire that the future state allows us to do the below:

- Long term joint financial planning to underpin investment commitments into programmes such as prevention. Moving from shadow joint investment to truly pooled programme budgets with clearly defined outcomes.
- Financial stability for health and adult social care within commissioning and provider organisations.
- Reduced demand on emergency and specialist health care, similarly recued demand on residential and long term care.

- Provider market stability and collaborative working relationships with the community voluntary sector.
- Reduced health inequalities, with better health and care outcomes for patients and a more positive experience for all residents.
- A strengths-based approach which enables health and care which maximises independence, self-care and utilises our local assets to contribute to health and wellbeing.
- Robust and transparent governance, scrutiny and oversight that allows for appropriate local leadership of health and care, and governance that enables further collaboration and integration.
- A stable and healthy workforce able to operate in a multi-disciplinary approach, unhindered by organisational boundaries.
- A productive and influential partnership within the Sussex ICS, shaping the strategic future of health and care provision to come.

Delivery of this plan will be monitored through established organisational mechanisms:

- Brighton & Hove CCG provides assurance against the delivery of our plans in the production and review of the Brighton & Hove monthly Integrated Contracts and Performance and the Quality Report. These comprehensive reports have been developed in line with the CCG's ambition to create a health intelligence system to ensure that timely, accurate and appropriate information is available to all relevant.
- Commissioning Teams also provide detailed quarterly updates on the progress against delivery of their plans, complementing regular deep dives into specific programme areas presented to Sussex Health and Care Partnership assurance meetings/ assurance via the programme delivery boards.
- Specific risks against indicators are captured in programme risks registers and are also strategically reviewed through the Board Assurance Framework (BAF).

Outcomes we intend to monitor and report on are included in Appendix A (Joint Health and Wellbeing Strategy indicator). In addition, we will be monitoring progress addressing health inequalities through the following indicators:

- Inequality in unplanned hospitalisation for chronic ambulatory care and urgent care conditions;
- Cancer screening (breast, bowel and cervical);
- Flu immunisation;
- New diagnosed cases of cancer diagnosed at an early stage;
- Cardiovascular Disease outcomes.

The immediate next steps for integration are as follows:

- Conclusion of the review of the Health and Wellbeing Board (HWB), independently facilitated. This will broaden membership to include wider system provider involvement including the voluntary care sector.
- Establishment of refreshed HWB related governance and working arrangements - New HWB terms of reference will determine review and realignment of supporting management groups such as the current Health and Social Care Integration Board and how they include wider involvement such as the Primary Care Networks (PCNs), and it will provide for a reset of interdependencies with other city groups such as the City Management Board and *Brighton Connected*.

- Development of delivery plan for the joint health and wellbeing strategy and year on year priorities aligned to delivery of NHS LTP in Brighton & Hove - leadership will identify priorities and of these the priorities that are best addressed jointly, ensuring the patient and public voice is heard, including engagement with Healthwatch. This will inform (a) immediate improved delivery opportunities such as management of Better Care Fund initiatives and (b) future fully integrated commissioning and delivery beyond collaboration to more formal alliances, contractual arrangements and joint / shared posts.
- System organisational development – To include facilitated development of HWB; build on learning from system partners having undertaken the NHSI *Transforming Care through System Leadership* course including the CCG, the City Council, SCFT, SPFT and BSUH; and identify further OD to support ICP development, particularly linking to Primary Care Network development across the city.
- All system partners in Brighton & Hove (CCG, BHCC, BSUH, SPFT, SCFT, Community Works, with the input of Healthwatch) have agreed to commit to the journey of becoming an ICP building the good work already taking place with the Aligned Incentive Contract; the multi-disciplinary work in Cluster 6 with SCFT/BHCC and a strong history of work with the voluntary sector.

The role of Healthwatch…

"People love the NHS because the NHS loves us .... we put our lives and future in their hands. It is a gift of trust. The most important issue for Healthwatch is that services put the patient experience first."

David Liley, CEO, Healthwatch Brighton & Hove

An insight into our Community Assets…

"We have 2330 third sector organisations in Brighton & Hove, a rich resource to draw upon in terms of existing assets within the city. 15% of organisations responding to a recent survey (2019) said their main activity centred round health and wellbeing whilst a further 27% said it was a secondary aim of their work. Each responding organisation reaches approximately 400 beneficiaries and many more groups and organisations provide community connection, support equality and diversity and cross sector working. The Voluntary and Community sector employs an estimated 7000 people and 51% of adults in the city volunteered at some point in the past year. The focus within the Long Term Plan of recognising the value of integrated working and the value the community offers in contributing to improved health outcomes means Brighton & Hove is ideally placed to focus on better integration of primary and secondary health systems with improved outcomes for people in the city. The Voluntary and Community Sector has developed successful partnerships with statutory providers and will continue to provide creative and sustainable ways to support people within the communities they live in or identify with."

Jessica Sumner, Chief Executive Officer or Brighton & Hove Community Works
October 2019

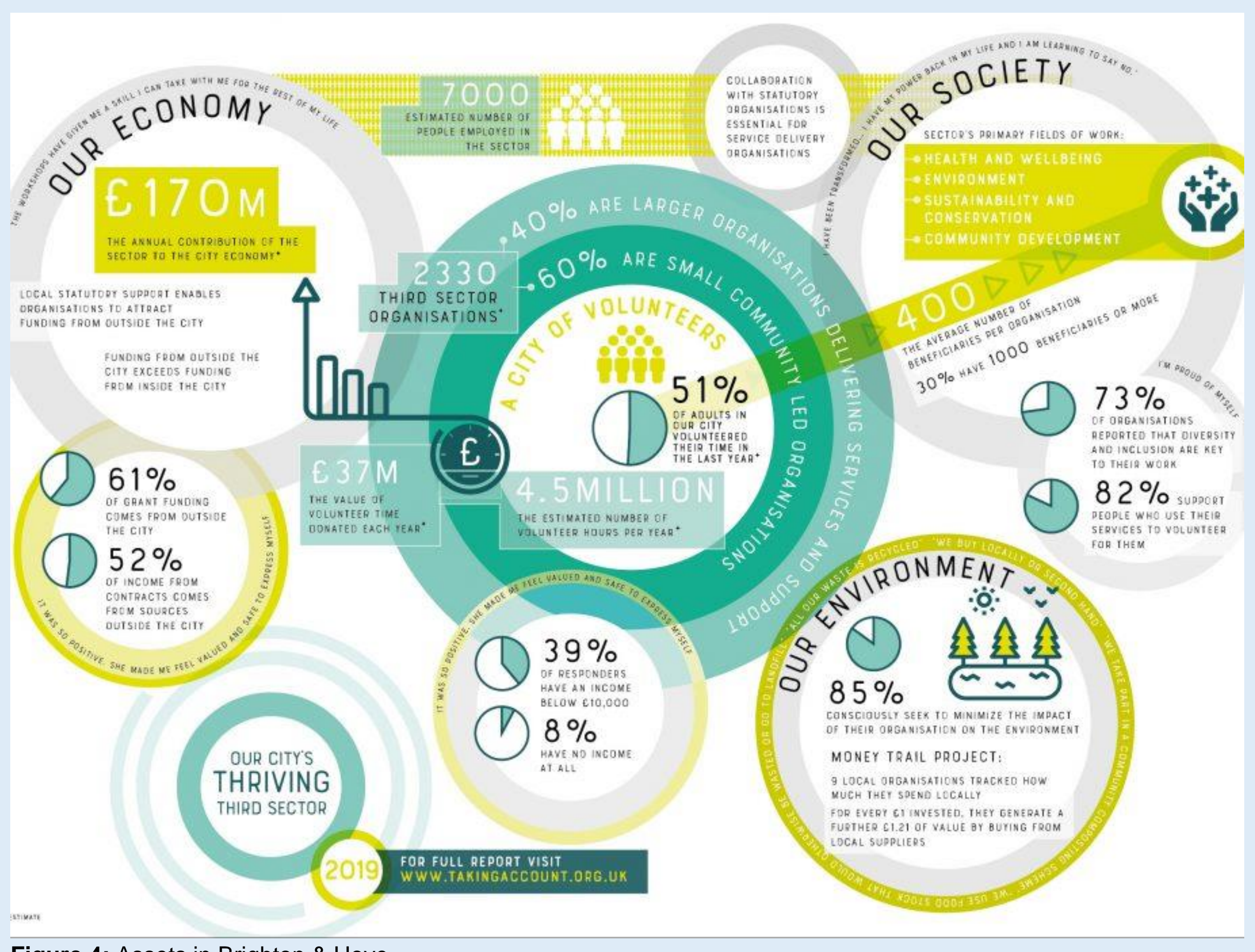


Figure 4: Assets in Brighton & Hove

3.6 System roadmap

We have set out some high-level milestones for our system development in Brighton & Hove:

2019-2020

- Develop place based integrated models of care under proof of concept and evaluation framework.

2020-2021

- Work with local PCNs to develop patient demographic specific pathways required to integrate with integrated care 'hub' core offering.
- Agree Sussex wide strategy delivering place based integrated care models.
- Commission agreed models.

2021-2022

- New models in place - integrating community and primary care services (PCNs).
- Systems should continue ongoing service improvement work so that performance is maintained and improved for A&E, to the point at which any new standards, proposed by the Clinical Review and accepted by Government, are implemented.

4 Meeting our NHS Long Term Plan commitments through the life course approach

4.1 Starting Well

An insight into how we engage with our young people…

"We are working with the Hangleton and Knoll Project within the west of the city to develop a group of disadvantaged young people into Health Champions. This involves supporting them to become engaged in the health agenda and to develop resources and information. A recent example of this was a project on bullying, which was taken into local schools."

Jane Lodge, Head of Engagement, Sussex Commissioning Alliance, October 2019

4.1.1 Integrating children's and young people's services

A programme of work has been undertaken over the last five years to integrate a multi-disciplined approach to children and families under the care of The Alex Children's Hospital. This includes psychological support for children with long term conditions and more recently a team to work with children with complex symptoms. The next stage of this work is to include the current team for Chronic Fatigue Syndrome/Myalgic encephalomyelitis in order to build up a more robust and inclusive service support physical & mental health in an integrated approach. In addition, the BSUH paediatric cystic fibrosis from across Sussex will be consolidated into one centre of excellence at The Alex Children's Hospital to improve the quality of care that can be provided.

We are working towards joint delivery and joint commissioning of children's community services with our local authorities, looking to build system wide solutions to the challenges of increasing complexity and workload across the system, in particular the pressure on therapies provision and increased tribunal work.

Work is underway scoping the commissioning and service gaps and barriers for transition from paediatric services for young people with complex health and special needs, which will include understanding the opportunities for PCNs and the role of primary care to support these young people as well as looking at NHS provision required in specialist schools. We will build upon our strong foundation in children and young people's mental health and transition to adult services through the Wellbeing Service and SPFT Specialist CAMHS Outreach team (provided up to age 25 years).

Community children's and adult services and commissioners are working together to understand the gaps and barriers to providing good transitions and appropriate support to young people to meet their health and care needs. It is recognised that the longer term vision is for a more multi-disciplined, joined-up approach between children and young people and adult services to increase individual independence. There will be further work with young people transitioning to provide training support to colleges and work placements and make links with other expertise.

4.1.2 Implementing Sussex wide programmes of work

Mental health

Brighton & Hove will work with the Sussex-wide working groups on mental health to implement the strategies as set out in the Sussex Strategic Delivery Plan. In line with our local priorities, children's and young people's mental health is a priority and so Brighton & Hove will work to make sure that the Long Term Plan commitments for children and young people's mental health are met, including Improved Access to Psychological Therapies (IAPT), new models of care, Family Eating Disorder Service, Crisis Response Service, Substance Misuse Services, and workforce development initiatives.

"Learning about mental health in school just like you would history or geography - makes it less of a big deal and more like any other bit of health" School student learning about Wellbeing at School – as told to Healthwatch Brighton & Hove

"I have anxiety and teachers are always telling me I need to speak up more sometimes I just want to leave the class and be able to talk to someone." School student on the need for Wellbeing support in School – as told to Healthwatch Brighton & Hove

In Brighton & Hove, work is ongoing to support the Sussex wide strategy, including:

- A wave Two Trailblazer, offering an opportunity to enhance our Schools Wellbeing Service already established across our schools which involves a Primary Mental Health Worker providing support to children and young people (one-to-one/group work) and a whole school approach to emotional wellbeing and mental health and supporting school staff and parents/carers. From 2020/21, a second Mental Health Support Team for schools will be introduced into the city.
- A robust Mental Health Liaison Team in place within the city.
- The Practice Hope project which will support ten GP practices in Brighton & Hove to provide appropriate, timely care and support to children and young people who are experiencing thoughts of suicide and self-harm.
- A whole school approach to emotional health and wellbeing as part of the Healthy Child Programme, including Mental Health First Aid.
- Specialist CAMHS assertive outreach model to bring together mental health professionals with looked after children, youth offending, substance misuse and adolescent expertise, supporting young people within our community rather than in secure estates but with clear step-down pathway when they do return from secure estates.
- Workforce development initiatives including a children and young people's emotional wellbeing and mental health workforce strategy and associated children and young people's IAPT training places and training for local authority staff, although more needs to be done to train up the workforce to support children and young people with autism spectrum conditions and / or learning disabilities and mental health conditions.
- A review of demand and capacity of Eating Disorder Services and development of a business case to expand the service to meet the 95% standard from April 2020.

Maternity

Brighton & Hove will also implement the maternity transformation plans being set out by our Sussex-wide Local Maternity System (LMS). These include delivery of the following projects/initiatives:

- Better Births and other commitments as set out in the Long Term Plan;
- Continuity of carer;
- Support for perinatal mental health conditions;
- Support for breastfeeding and infant feeding;
- The provision of Healthy Futures teams to support vulnerable families;
- Health visiting to complete the five mandated checks on infants.

Recognising our current starting point is delivering on personalisation and choice, a key focus for Maternity commissioning in Brighton & Hove together with partners across the Sussex Health and Care Partnership Area is the development of a Midwife Led Unit (MLU) in order to provide women a choice of three options for intra-partum care: home birth, obstetric-led pathway or midwife-led pathway of care. There is potential for the MLU to be co-located with one of the two Consultant-led units in order to provide the choice for three types of place of birth in Brighton & Hove; this will be key to delivering improved service/safety and access to women in Brighton & Hove.

There are several other initiatives that will positively impact Brighton & Hove will be led by the Local Maternity System (LMS). The key milestones for delivery are as follows:

In 2019/2020:

- BSUH have received LMS funding to commence the Baby Friendly Initiative accreditation/re-accreditation, with an aim for full level three accreditation by 2024.
- Community Hubs – a baseline assessment of service provision has been completed, mapping Local Authorities service offers in shared locations. Stakeholder mapping is currently underway involving the Community and Voluntary Sector (CVS). Task and Finish Group is being set up to progress the development of a service specification and operating model for community hubs and to set out place-based responsibilities for operationalising hub models including location, core services that will be offered and reflecting local needs with additional services.
- A robust programme of staff engagement for continuity of carer has begun, to support a culture change. Expansion plans for the continuity of carer approach are in place in all providers, with this being mobilised by Q4. BAME women and/or those from vulnerable groups will have targeted teams.
- A mapping exercise of current maternal medicine pathways and referral processes will be undertaken across the Sussex and East Surrey LMS.
- The LMS Clinical Lead and Better Births Trust Consultant Obstetricians will review local baselining information and maternal medicine service specification to provide a clinical view on the feasibility of having a Maternal Medicine Network within the LMS.
- The postnatal pathway will be mapped across LMS alongside the postnatal service delivery model and current physiotherapy involvement in maternity pathway, including any involvement with birth trauma. A task and finish group will be developed to provide a full LMS response to the Post Natal Improvement Plan, including Better Births requirements for March 2020 - including scoping of demand, referral rates and capacity of uro-gynaecology, obstetrics and gynaecology and colorectal services, information to women about postnatal return to health, scope

current antenatal information and physio support to women for preventing/mitigating pelvic health concerns post birth, including a targeted approach.
- A Pre-term birth clinic will be put in place at BSUH.

In 2020/2021 onwards:

- Foetal medicine referrals and provision in Sussex will be scoped and reviewed against data on maternal medicine referrals.
- A review of the information gained from the previous milestone will be take place in the context of the National Clinical Content Repository (NCCR) and provide an options appraisal for consideration on foetal and maternal medicine to the LMS, Clinical and Professional Cabinet of the Sussex Health and Care Partnership. Maternity Voices Partnership (MVPs) will be involved to ensure the service user voice informs the options appraisal.
- Continue to support implementation of new Maternity Information Systems, working with the Trust implementation team.
- We will work with the Trust to identify information governance issues, which may affect interoperability and escalate to LMS partners to resolve, linking with the Sussex Health and Care Partnership Digital Lead.
- We will identify training needs for staff around consent to share information and consider how we build consent into digital system development.
- Implement the postnatal improvement action plan and monitor KPIs/outcome measures agreed for improvement and scope best value model locally for physio support - linked to PCN physio offers and existing services. Work with PCNs to establish primary care physiotherapy role in supporting the prevention of pelvic health.
- LMS and all relevant stakeholders to consider applying to become an early implementer of Pelvic Health Clinics.

In 2021/22 and 2022/23, the LMS will monitor early learning and information from the pelvic health clinics and the commissioning intentions in 2022/23 should indicate commissioning of Pelvic Health Clinics from 2023/24 funded through LTP fair shares.

Childhood immunisations

In order to address the relatively low rates of uptake of childhood immunisations, a cross system action plan will be developed for the city. As a system we welcome the review of GP vaccinations and Immunisation standards, funding and procurement within the Long Term Plan and will take an active part in reviewing systems with other partners across Sussex through the Prevention Board.

Learning disabilities and autism

Brighton & Hove will continue to participate in the Transforming Care programme, including:

- Increased capacity in pathways for Autism Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD). The re-development of the Autism pathway will enable provision of a multidisciplinary holistic service for children and young people as a collaboration between SCFT and SPFT. The aim is for a single entry point to be in place by 2021 and it is anticipated that this project will positively impact the waiting time for autism assessments and increase capacity for follow-up support.

- Ensuring Health Checks are in place for 14+ years, and the STOMP-STAMP approach is used to ensure young people with a learning disability and/or autism are given the right mediation, at the right time, for the right reason.

4.2 Living Well

An insight into how we engage with our People…

"From 2013 to 2017, the CCG commissioned a number of Voluntary and Community Sector (VCS) organisations to help us to reach and hear from people and communities who are marginalised or have high health inequalities. Following this, the CCG and BHCC have commissioned ten VCS organisations under the Third Sector Investment Programme, to engage with local people in specific groups such as BAME, carers, young men, people with disabilities on health and social care.

Alongside this, the Hangleton and Knoll Project is funded to develop and maintain the West Hove Health Forum which includes primary care, community organisations and local people. This provides a way of engaging with this community and seeking views, of providing information and co-developing solutions to local issues."

Jane Lodge, Head of Engagement, Sussex Commissioning Alliance, October 2019

This plan aims to improve the health and wellbeing of working age adults in Brighton & Hove through:

- Provision of information, advice and support to help people to eat well, move more, drink less and stop smoking to reduce their risk of developing long term health conditions. Local people and communities will be encouraged to make the most of these opportunities to improve their health and wellbeing.
- Improvement of mental health and wellbeing support, including plans to enable easier access to responsive mental health services locally.
- Improvement in sexual health, including reduction in new HIV infections.
- Support for people to improve their wellbeing at work.
- Support for people with disabilities and long term conditions, and the long term unemployed, to gain employment.

4.2.1 Primary prevention

The Brighton & Hove City Council Healthy Lifestyles Team and commissioned services support individuals and families wanting to make changes to their lifestyle and improve their health and wellbeing by:

- Stopping smoking
- Moving more and increasing physical activity
- Achieving and maintaining a healthy weight
- Improving nutrition
- Drinking less alcohol
- Improving general wellbeing

These services support the primary and secondary prevention of (and recovery from) cardiovascular disease, respiratory diseases, mental health problems and cancers. The referral system is a one stop shop for individuals and providers to provide support, advice, signposting and referrals to other services. In addition the team supports communities,

schools and workplaces to provide healthier environments.

In Brighton & Hove Tier 2 weight management services are delivered by BeeZee Bodies. However there is an additional need to expand Tier 3 weight management services for Brighton & Hove residents. This is being taken forward at the Sussex level but will require local support and implementation.

The Prevention workstream of the Sussex LTP response includes additional prevention priorities where it makes sense to take these forwards at Sussex level, for example, the expansion of Stop Smoking Services for patients in NHS settings and increasing the capacity of the subsequent pathways.

4.2.2 Planned care

Reducing waits

In Brighton & Hove we are implementing a set of measures to reduce waiting times by focusing on improving patient pathways including plans for the introduction/continuation of the following initiatives:

- Referral management initiatives;
- Advice and Guidance support for GPs, improved referral guidance, standardised referral forms and online referral activity reporting for primary care to aid GPs with appropriate referrals;
- Streamlined pathways to reduce clinical variation and improve patient flow;
- Improving the referral criteria and capacity in diagnostics;
- Adherence to national evidence-based interventions and policies and locally developed clinical effectiveness policies.

BSUH has set out a new Clinical Strategy for 2019-2024 to provide an overarching strategic direction for the Trust's clinical services. Many of the priorities in BUSH's Clinical Strategy and Clinical Sustainability and Transformation Strategic Initiatives will reduce waiting times:

- Outpatient productivity and utilisation;
- Outpatient transformation and new models of care to support 3Ts Phase 1;
- Theatre productivity, utilisation and efficiency – including investing a second obstetrics threat and robot, and ensuring optimal utilisation through centralisation of theatre management including pre-operative assessment and streamlining patient flows;
- Maximisation of day case capacity and activity;
- Development of PRH to carry out more ambulatory outpatient, rapid diagnostic and day case activity, including a Urology Investigation Unit to provide patients with a one-stop clinic.

To reduce length of stay, we are investigating Getting It Right First Time (GIRFT) based length of stay opportunities, looking at implementing a speciality rolling programme.

There has also been a deterioration in performance against the 6-week diagnostic standard. To improve in this area, we will work on a set of plans to include:

- Imaging Did Not Attend (DNA) reductions and booking efficiencies;
- Additional capacity development for endoscopy and imaging;
- Non-obstetric ultrasound system-led demand management scheme;
- Faecal calprotectin project to reduce endoscopy demand.

To reduce referral to treatment (RTT) waits, BSUH is working across the system on several outputs including the following:

- Outpatient transformation (described in section 4.2.3);
- Maximisation of day case capacity and activity;
- Referral demand management;
- A super-stranded patients project, using national benchmarking. This may involve specific support for super-stranded patients with contributing factors such as alcohol/substance misuse, self-harm etc.

BSUH is also engaged in Pathology Network Development, as a joint venture with Sussex and Surrey Healthcare Trust on a programme of centralisation and consolidation throughout 2019/20.

The 3Ts Build Programme at the Royal Sussex County Hospital site in the city centre will also have a considerable impact on planned care, with completion of Phase 1 due in 2019/20, and confirmation of Phase 2 and 3 in forthcoming years.

Musculoskeletal conditions

We will implement access to First Contact Practitioners to provide faster access to diagnosis and treatment, and support more effective self-management for people with musculoskeletal (MSK) conditions. We are well prepared to implement this as the MSK Central Sussex service for Brighton & Hove patients already allows self-referral to physiotherapy as first contact. Providers and commissioners will ensure sustainability of MSK services at BSUH as a teaching and major trauma centre.

Patient choice

Choice has been an integral part of our patient offer for over ten years and we will continue to ensure patients have the opportunity to choose who provides their care, including when and where, at the point of referral.

In Brighton & Hove, we currently commission elective services from a wide range of NHS and Independent sector providers in the region as well as supporting referral further afield. This is underpinned by a Referral Management Service (RMS) whose role is to deliver and manage choice at the point of referral. With the recent introduction of the Electronic Referral Service there is even greater opportunity for patients to explore and take advantage of the options open to them. In the course of the 2020/21 we envisage transferring control of the RMS to Primary Care Networks and will work closely with them to maintain and improve upon our choice delivery mechanisms. We will also explore further opportunities for patients to access there are across a wider regional geography, particularly where there is spare capacity and shorter waiting times. Related to this, we are working to identify services that would benefit from the mobilisation of Capacity Alerts on e-RS to sign-post patients in Primary Care to where there are shorter waits for planned care within the system upon referral.

We are working together to ensure the 26-week-wait policy is fully implemented by April 2020 and are working with the Elective Care Transformation Programme to discuss how to implement this successfully. We will seek to ensure that any patient who has been waiting for 26 weeks or more for their first definitive treatment is offered the opportunity to be treated sooner by an alternative provider.

4.2.3 Transforming outpatients

We are working together across the system to deliver on the ambition to transform how we access/follow up treatment that has traditionally been place in outpatient departments. Analysis across several indicators to identify where opportunities sit within outpatient services, and benchmarking against peers, identified that we are an outlier for general surgery and neurology.

In 2019 we piloted tele-ophthalmology using new technologies to change the treatment approach to how we treat Age Related Macular Degeneration. This new approach enables specialist community optometrists to improve referrals, have them assessed remotely by

An insight into our tele-ophthalmology pilot…

"Since May 2019, the CCG and BSUH have been working collaboratively as a pilot site for the NHS England Elective Care Transformation Programme workstream around ophthalmology, 'EyesWise'.

This project focused on the implementation of virtual clinics for Wet Age Related Macular Degeneration (wAMD). Recognising that being seen in a virtual outpatient clinic is different to the traditional face-to-face model, a Macular Forum was set up to engage with patients, the public and the third sector around new models of care. The forum provides a platform to:

- Explain new models of care
- Manage expectations around who patients will be seen by, where and at what interval
- Provide healthy lifestyle advice and signpost to local support services
- Ask question and gain answers, including with speakers from local support groups and charities
- Feedback

Key outcomes:

- Patients are educated and empowered about their condition
- Improved patient experience
- Patient expectations are managed
- Effective, joined up working"

"This project has given us the opportunity to rapidly progress with changes we've wanted to make for a long time, such as implementing the Macular Forum". - EyesWise Consultant, BSUH

"I so much enjoyed meeting other people like me, sharing experiences and hearing more about the service –I'm looking forward to the next forum". - Patient

"This project was a fabulous example of what can be achieved when clinicians, managers and commissioners work together to improve patient care. The whole team got stuck in and, despite significant pressures, we also enjoyed it." – Planned Care GP Clinical Lead, B&H CCG

"This project allowed us to work collaboratively to bring about fast paced change, with the patient forum being one example of what we've achieved through this project." – Planned Care Lead Commissioning Manager

Dr Cottam, Planned Care GP Clinical Lead, B&H CCG
Katherine Johnson, Planned Care Lead Commissioning Manager, B&H CCG
October 2019

hospital consultants and where appropriate, provide review and routine follow up without the patient needing to return to the hospital. This reduces the pressure on the hospital department, increases the workforce and significantly improves the patient experience. We will be using this project as a template for service transformation across other specialities, seeking to replicate this type of pathway wherever appropriate.

Similarly, we are supporting development of primary care based tele-dermatology that allows images and case symptoms to be reviewed by specialists prior to referral. This pre referral review means many conditions can, using specialists' advice and guidance, be treated in the community without a visit to the hospital outpatient departments.

In 2019-2020, we will deliver programmes around ophthalmology, urology, neurology, gastroenterology, expanding this to a Digestive Diseases Programme, in 2020-21 and further programmes in 2021 onwards. Phase 1 of the 3Ts Build Programme will also support, and be supported by, outpatient transformation and new models of care.

We will continue to work across the system and with the Sussex Outpatient Transformation Board to enable the delivery of outpatient transformation across Sussex. More detail on the system-wide outpatient plan is available in the Strategic Delivery plan.

4.2.4 Respiratory services

The integrated respiratory service in Brighton & Hove is consultant-led and includes specialist medical, nursing and psychology and therapy support. The consultant acts as Chronic Obstructive Pulmonary Disease (COPD) lead for the local health economy and leads on the development of both the service and care pathways.

This service is commissioned to deliver on an agreed number of outcomes, which include; identification and referrals to pulmonary rehabilitation services and a more proactive approach to early identification, diagnosis and intervention. The service requires the providers to work collaboratively with partner organisations in the local health economy to deliver a sustainable model of care.

GPs and the Integrated Primary Care Teams (community nursing/district nursing) have primary responsibility for the patients who are stable and/or have mild – moderate disease, and the integrated respiratory service managing a cohort of patients with more severe disease or those who are acutely unwell. Clusters of GPs have an assigned respiratory clinician from the service to ensure equity across the city, and access to specialist support and guidance as and when required.

The service operates in tandem with a Locally Commissioned Service (LCS) for COPD, with the specialists in respiratory care providing support and education to primary care and the clusters of practices to improve early, accurate diagnosis of disease and optimisation of treatment. Intensive clinics are out of hospital. A specific focus is given to patients who are currently not engaging with respiratory services. As a high proportion of people with COPD also have anxiety and depression, this service will embed parity for mental health needs in the pathway of care. The COPD LCS is being reviewed to identify opportunities for enhancement e.g. training and incentives to review medication. This LCS will also be reviewed in light of alignment of LCSs across Sussex ICP, with scope for service to potentially be delivered on a PCN-basis.

The city also offer support via Brighton & Hove Breathe Easy Group which is a social and support group for people with COPD, asthma and other respiratory conditions. This offer has

now been expanded with a new group in Central Brighton and we will continue to increase the number of sessions and locations.

We are currently in the exploration stage of offering the myCOPD app to patients who present to the community respiratory team following successful roll out in our neighbouring High Weald Lewes Havens CCG.

4.2.5 Personalised care

Personalised care helps a range of people, from those with long- term illness and complex needs through to people managing mental health issues or struggling with social issues which affect their health and wellbeing. It helps them make decisions about managing their health so they can live the life they want to, based on what matters to them, working alongside clinical information from the professionals who support them.

This is in response to a one-size-fits-all health and care system that simply cannot meet the increasing complexity of people's needs and expectations. Evidence shows that people will have better experiences and improved health and wellbeing if they can actively shape their care and support plans.

Shared decision making

While shared decision making is present in most services it has been particularly pursued within local MSK services, using a structured approach. Over the next five years we will take learning from MSK and elsewhere and systematically embed this within all areas of the elective care system, to ensure patients are supported to make well-informed choices about their care and treatment. We will also be embedding the Making Every Contact Count (MECC) approach into the shared decision making process to include aspects of prevention and improvement of overall wellbeing.

Social prescribing

Social prescribing (SP) is well established in Brighton & Hove, predominantly led by the Community and Voluntary Sector, in conjunction with Primary Care and is supportive for many points within a person's health journey. The existing established service began in 2014 and developed into the citywide provision to GP services available today as an important component of prevention, keeping people with long term conditions well and hospital admission avoidance. The existing primary care social prescribing service has been the subject of a rapid evaluation. The evaluation found that overall, SP is well received and considered beneficial for both patients and GP Practices. A subsequent service redesign is taking place in collaboration with PCNs to ensure that the future citywide SP support is complementary and in line with PCN plans for link workers and national guidance on SP.

Brighton & Hove City Council will work closely with its affiliated community development organisations and support collaboration between community development and SP providers. We also jointly commission the My Life website, an easy-to-use, online directory listing local Brighton & Hove and national organisations and services to support everyday living, including meaningful social activities.

The Link Back service provides social prescribing support to patients being discharged from hospital. A review of this service has identified the value of social prescribing for this group of people and indicated a need for greater cohesion across services that support people out of hospital and further work is planned to align and streamline pathways. This will take place in Q3 2019/20 in preparation for the embedding of Primary Care Link Workers in PCNs in forthcoming years.

More specialist SP support is also available within the city for people living with and beyond cancer, and their families. The Macmillan Horizon Centre is located next to the Sussex Cancer Centre at the Royal Sussex County Hospital and offers a range of support, for people affected by cancer including information, advice and support. Further work needs to be undertaken with community outlets such as pharmacies to ensure they are aware of support available (e.g. Macmillan Horizon Centre and support groups) for those affected by cancer in order to appropriately signpost them.

Over the next few years, we will continue to build on local examples of SP to embed the approach across the whole life course to help people to recover from their illness and when that is not possible, to manage their condition and enhance engagement with their own treatment plans to improve their experiences.

Personal health budgets

Personal health budgets (PHB) support the vision of a more personalised, patient-focused NHS, and offer additional opportunities for health care professionals and people to work in partnership, making shared decisions and actively co-designing services and support. This partnership combines the professional's vital clinical expertise and knowledge with the person's expertise in their health condition, and their ideas for how their needs can best be met.

By December 2019, we will have reviewed what is required to deliver the PHB process and will establish a stakeholder group by January 2020 to design the process locally. The roll out and performance management will commence from May 2020.

We will work together to ensure that;

- All stakeholders, including local people, understand what can be locally funded as part of a PWB - which will be the starting point for stakeholder group;
- The Model Service Specification Core Principle is adopted through stakeholder group and with support from NHSE Mentor;
- People have the information available to make an informed decision about a PHB;
- There is aligned understanding about the process and steps service users need to take e.g. making contact and getting clear information and working out the amount of money available;
- There is support for proactive co-ordination of care and choice and control for service users;
- Roles, responsibilities and accountability for PHBs are clearly understood;
- Local workforces are confident, trained and supported to help people access, choose, take up and manage a PHB in a way that helps them achieve their personal outcomes;
- The PHB process will be monitored as part of the local provider performance management group meeting and any issues escalated to the contract management board.

The Brighton & Hove Continuing Healthcare (CHC) team have recently invested in their administration team to ensure personalisation is part of the daily work within the team.

In 2019/20, we are working to increase the uptake of PHBs for S117, Learning Disability and wheelchairs. We have an end of year target of 320-450 PHBs to be in place, in line with NHSE targets.

We are working closely with the local provider to develop a plan for local wheelchairs which will include establishing a working group with service users and support from an NHSE Mentor to implement the next steps.

We are also currently focusing on supporting direct payments for clients to have more control of the care they receive. A review is in progress with plans to simplify the process for local residents.

From April 2020, PHBs will be incorporated into business as usual for community clients, with a view to extending to individuals who are in a residential setting by April 2021.

4.2.6 Local priorities: trans locally commissioned service in primary care

Responding to issues raised by our population there is a recognised gap and level of need in services for supporting our transgender population. An audit of local GP practices showed there were significant difficulties for transgender and non-binary patients such as long waits to receive prescribed hormone treatment. Brighton & Hove CCG are developing initial service costing and plans to initiate a three-year pilot service to fill this gap and improve the services for this population cohort. If we succeed, we would be proud to be the first CCG to do this in the country.

4.2.7 Implementing Sussex wide programmes of work

We will work closely with the Sussex-wide programmes of work to implement strategies at place.

Mental health

Brighton & Hove is characterised by a number of known inequalities directly impacting on mental health and the demands being placed on service provision. Integration of health and social care as well as an alliance between the physical and mental health context is vital moving forward. This can only take place with a clear focus for the place (Brighton & Hove), as well as whenever possible, for the wider population based enterprise of the Sussex Health and Care Partnership.

The challenges specifically faced by Brighton & Hove in the context of mental health are:

- A higher proportion of University students. It is understood that this population can experience social and/or personal isolation as well as uncertainty due to the absence of family supports;
- A significant population of older people including a notable prevalence of dementia;
- A higher proportion of LGBTQ+ people within our community.

Both primary and secondary care has a significant role to play. However, the strong presence of the voluntary and not for profit sectors locally is well evidenced and makes a significant contribution.

We will work to integrate mental health across all plans and services and continue to maintain comprehensive service user involvement in this area of our plans, to mitigate the challenges we face. Services provided at Sussex level that will be implemented in Brighton & Hove to mitigate these challenges include:

- Services for homeless people, with a city-wide homelessness and rough sleeping strategy due for publication and action in 2020/21;
- Physical health checks for those with serious mental illness from 2019/20;

- Early Intervention in Psychosis, to achieve 60% access in 2020/21 and 95% by 2023/24;
- Mental Health Supported Accommodation Review;
- Meeting the mental health investment standard;
- Enhancing the Brighton & Hove specialist service for community perinatal mental health to increase the number of women receiving treatment;
- Increased access to crisis pathways;
- Community teams for adults with severe mental health illnesses;
- Access to an enhanced Eating Disorder Service for adults from 2021/22;
- Opening of the 'Haven' at Millview Hospital, a Psychiatric Decision Unit to provide an alternative location for people in crisis to which the police, ambulance services and other professionals may refer from 2019/20.

In addition, to support delivery of IAPT, throughout 2019/20 20 Psychological Wellbeing Practitioners (PWPs) and 29 High Intensity Therapists (HITs) will be trained for future work within IAPT across Sussex, followed by 19 PWPs and 35 HITs. In 2020/21, estates solutions will be agreed for IAPT expansion aligned with the integrated PCN and community model.

Brighton & Hove has developed a place-based Suicide Prevention Plan in line with the National Suicide Prevention Strategy. Due to the high rate of suicide in Brighton & Hove this is a key local priority. The strategy has been developed and will be monitored by the Suicide Prevention Strategy Group. The strategy is delivered by partnership approach across the Council, NHS (including specialist mental health services, the CCG, primary care and A&E) and community and voluntary sector and communities. Priorities include:

- Reducing the risk of suicide in key high-risk groups;
- Tailoring approaches to improve mental health in specific groups;
- Reducing access to the means of suicide;
- Provision of better information and support to those bereaved or affected by suicide;
- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour;
- Supporting research, data collection and monitoring;
- Reducing rates of self-harm as a key indicator of suicide risk.

The Brighton & Hove community recovery service integrates drug and alcohol treatment services. The current service will be re-procured in 2020 and the requirements of the new service specification include the full range of structured treatment interventions to support people to achieve 'recovery' from drug and/or alcohol dependence. The service will also deliver outreach to marginalised groups including the street community and rough sleepers, complex case management for people with co-occurring mental health issues, proactive engagement to ensure equitable access for minority groups and transitional support for young people. The service will also work with partners to:

- Ensure an effective multi-agency approach to safeguarding children and vulnerable adults;
- Work with statutory services to keep families safe;
- Address anti-social behaviour and drug litter;
- Provide specialist support for GP prescribing;
- Work with NHS colleagues to provide a hospital liaison service;
- Support shared care with GPs for stable patients;
- Work with prisons and the criminal justice system to ensure robust referral pathways and support integrated offender management;

- Provide a range of interventions to support the development of recovery capital and mutual aid.

The re-procurement of substance misuse services will also include a 24-hour, 365 day, inpatient detoxification service, delivered by a multi-disciplinary team.

It is increasingly recognised how vulnerable the higher education student population is, and this is a particular concern within the city due to the presence of two large universities and Medical School. In Q1 2020/21 we will undertake a mapping exercise to identify the support currently available to this population group between the NHS, BHCC, universities and the community and voluntary sector. We will also collaborate to research examples of good practice nationally to explore the potential for development of these locally.

Sexual health

The Sexual Health and Contraception (SHAC) integrated service in the city is provided by Brighton and Sussex University Hospitals Trust. The service is delivered from three sites across the City with a mix of walk-in and booked appointments and specialist clinics (e.g. for transgender people).

The service also provides:

- 'Self-sampling' kits to be used at home and returned to the service for testing.
- A chlamydia screening programme for under 25s
- A programme of sexual health promotion outreach
- Condom distribution.
- A local sexual health website: www.brightonsexualhealth.com

The current contract has been extended for a period of two years (until 31st March 2022) to allow for the development of a co-commissioning model and to jointly develop a local sexual health plan with local and national NHS partners, in line with the requirements of the review by the Secretary of State for Health and Social Care (June 2019).

Cancer

C is in his late 60's. He had a routine bowel screening test which turned out positive and was given a colonoscopy within two weeks. He was told immediately that he had bowel cancer and was followed up with a conversation with a specialist nurse on what would happen next, with time for questions and to raise concerns. He was told to bring someone with him, and his daughter was also able to support him through the process. He was operated upon within two weeks. He stayed in hospital, which was what he expected, and then his discharge went well. Within two weeks, as he had been told, he was given the results of the surgery. He feels the whole experience was exemplary and is very optimistic about the future. – C's story – as told to Healthwatch Brighton & Hove

Cancer has been identified as a priority across the Brighton & Hove system, and so the focus is on implementing the Sussex-wide cancer plans across Brighton & Hove. Areas of focus include:

- Early diagnosis, supporting development and delivery of the Rapid Diagnostic Services programme and improving prevention and screening uptake;
- Improving patient experiences with cancer care;

- Increasing personalised care with 70% of cancer patients to have access to all elements of the recovery package 2020, including health needs assessment, treatment summary, and access to a health and wellbeing event;
- Compliance with national cancer standards, including the Faster Diagnosis Standard;
- Reduce unwarranted variation in cancer outcomes.

Key milestones for cancer care locally are detailed as follows:

- From Q4 2019/20, HPV primary screening will be in place locally;
- Throughout 2019/20, we are working with the Surrey and Sussex Cancer Alliance and other health systems within Sussex to develop Rapid Diagnostic Services for delivery in future years;
- From April 2020, patients will receive a diagnosis of cancer (or have it ruled out) within 28 days of referral from their GP;
- By 2021, where appropriate every person diagnosed with cancer will have access to personalised care;
- By 2023, stratified follow-up pathways for people who are worried their cancer may have recurred will be in place for all clinically appropriate cancers;
- By 2028, 75% of cancers will be diagnosed at stage 1 or 2.

Further detailed information on our plans for cancer can be found in the Sussex and East Surrey Commissioners Cancer Plan.

An insight into how we work with the CVS…

"The CCG, BHCC Public Health, and Albion in the Community work together closely to:

- Raise awareness of cancer through match day events
- Promote uptake of screening through targeted community outreach
- Reach out to marginalised communities through innovative use of outreach and social media."

Imran Yunus, Cancer Commissioner, Brighton & Hove CCG, October 2019

Diabetes

Brighton & Hove continue to provide diabetes-related services, and will implement the Sussex-wide strategy on diabetes:

- Brighton & Hove provide an integrated community diabetes service Diabetes Care for You (DC4Y) which meets its 8-week intervention target for patients;
- The service is keen to explore digital options for the delivery of education to increase access, awaiting the roll out of the national HELP digital package;
- There are continuing plans to work with primary care on prevention, using locally commissioned services and medicine management to improve diabetes prevention and care services;
- Brighton & Hove support the implementation of the Pan-Sussex Multidisciplinary Diabetes Foot Care pathway to improve quality of life and reduced need for amputation through timely treatment of ulcers

"E has dementia and recently had a stroke. The ambulance was called, and the crew resolved the stroke but still suggested he go to hospital for knee pain he was experiencing due to an operation on his leg he had had earlier this year. His hospital visit resulted in a nine-hour wait in A&E, due to no bed being available and followed with a five week admission for Ernest. The hospital admission has put us back six months in terms of E's ability to walk and in his confidence in general. Walking is now limited, requiring constant help to move around our bungalow and he no longer enjoys sitting in the conservatory. He lost a stone of weight while in hospital." – Patient's family member – as told to Healthwatch Brighton & Hove

Brighton & Hove is working within the Sussex-wide approach to Urgent and Emergency Care to provide an integrated network of community and hospital-based care and reduce emergency care pressures.

The programme focuses on avoiding unnecessary hospital admissions through our community service pathways, in partnership with primary care and SECAmb. Across Brighton & Hove, we have been working to develop and implement a consistent model of integrated urgent care (IUC).

Our model is fully aligned to the wider Sussex model and includes the following core elements:

- Digital front door (via NHS111 and Clinical Assessment Service) enabling effective care navigation and signposting patients to the most appropriate service to their needs.
- "Bookability" – the ability for NHS 111 and the Clinical Assessment Service (CAS) to book an appointment at the appropriate service for those patients who need to be seen face to face. This will include appointments at GP practice primary care improved access hubs and other community services, urgent treatment centres (UTCs) or A&E for the most critical and emergency cases. It will also allow access to repeat prescriptions to be ordered without the need to see a GP (when it is appropriate and safe to do so).
- UTCs providing 7 day a week 8am-8pm consistent access for diagnosis and treatment of many of the most common ailments for which people often attend A&E. Within the city, a UTC will be provided at the Royal Sussex County Hospital.
- Extending frailty services in acute settings to ensure people requiring hospital care receive timely frailty assessment and upon discharge are supported to return to their home/care setting in conjunction with community services to reduce frailty severity. An acute frailty service operates on the acute floor at the RSCH site providing a service 12 hours a day, 7 days week; incorporating the Acute Ambulatory Unit.
- At BSUH, patients will have access to Same Day Emergency Care (through the Emergency Ambulatory Care Unit) provided from 8am-10.30pm Monday to Friday and 8am- 8pm at weekends.
- Responsive Services delivered by SCFT across the city every day of the year will continue to provide a response within two hours where clinically assessed to do so. The service is a MDT comprised of nurses (physical and mental health), physiotherapists, occupational therapists, responsive service assistants and community Medication Review Pharmacists who support the delivery of rehabilitation

and/or reablement of patients in their own homes or place of usual residence to achieve goals related to their independence and quality of life; supported discharge from acute and community beds at the earliest opportunity; and avoidance of admission to acute beds.

A High Intensity User (HIU) service is being developed to support demand management in urgent and emergency care from 2019/20 and will offer a health coaching approach to users of services whose needs are often unable to be met fully by one area of service (including homeless people and those experiencing substance misuse). It is anticipated that this service will work closely with the existing HIU MDT team at BSUH as well as with other local services as appropriate.

The CCG and BSUH are also working closely on the preparation of a detailed plan for reducing Delayed Transfers of Care and Long Lengths of Stay.

Unwarranted clinical variation

As part of the system-wide Unwarranted Variation Programme Brighton & Hove are focusing on cardiology and MSK where there is material variation from peers. Over the next five years this programme will develop, and Brighton & Hove will be part of commissioning new pathways across other specialties.

4.3 Ageing Well

BHCC and CCG attended the September 2019 NHSE and NHSI launch event for the national Ageing Well component of the Long Term Plan. At place the system aims to improve local system use of the Community Services Data Set CSDS as this was requested as a fundamental building block for unlocking the full potential of clinical and digital transformation.

Other core principles included:

- Involving patients and carers, from the beginning and the whole way through service development
- Having essential conversations about complex needs and future care
- Developing effective MDT, especially at PCN level
- Moving from a “What’s the matter with you?” to a “What Matters to You?” approach
- Developing new roles to deliver Ageing Well effectively – paid carer career pathways, care home education roles, MDT facilitator and administrator roles, link pharmacy, link workers
- No wrong front door concept for any point of access contacted
- Shared information for direct care and research and improvement processes
- Using shared performance outcomes for primary, community and social care, including shared governance
- Rationalising assurance and evaluation processes, and ensure the data we collect matter

4.3.1 Transforming out of hospital and community care

Our plans for transformed out of hospital care

Brighton & Hove will continue to be a place where people can Age Well. Local and national ageing well programmes will improve the responsiveness of community health crisis response services, to prevent unnecessary admissions to hospitals and residential care, as well as ensure a timely transfer from hospital back to the community.

Our out of hospital transformation in Brighton & Hove takes a strengths-based approach, promoting a social model of prevention, which complements a traditional clinical approach. It builds on the social determinants of health working in collaboration with professionals across the system, as well as community and voluntary sector, families and individuals. It works on building people’s resilience to engage with wider support networks, supporting people to remain independent in the community by shifting focus and resource from acute towards community settings.

We are looking to develop integrated models of care and focus on keeping people out of hospital. The work will be based on the “One Croydon Alliance” example, establishing a single team across health and social care to proactively plan and review the care and support available for their patients with particular focus on those at risk of admission through factors such as loneliness, mobility problems and long term conditions.

This model forms the heart of integrated primary and community care, and is supported by a wide set of supporting priorities in the transformation of out of hospital care:

- Develop and deliver Primary Care Networks through implementation of the Sussex-wide Primary Care Strategy from 2019/20;
- Support integrated MDT working at PCN level to proactively recognise and respond to those with increasing needs, building on the initial progress with Goldstone PCN;
- Support PCNs to collaborate with other community services to offer local coordinated health and social care as set out in the Direct Enhanced Service (DES) contract;
- Shape services in line with urgent community response, enhanced health in care homes and anticipatory care requirements of the NHS Ageing Well requirements;
- Develop plans for resilience and workforce development, recruitment and retention;
- Develop model of same day primary urgent care services which can be implemented in Brighton & Hove;
- Deliver the High Impact Time to Care Programme to release capacity for patients needing face-to-face appointments in Primary Care;
- Deliver online consultation as per the Long Term Plan requirement;
- Develop and implement the South Place Frailty Strategy;
- Implement the recommendations of the Community Beds and Community Intermediate Care Services review;
- Extend and Improve Access to primary care and community services;
- Development of population health approach in PCNs;
- Implementation of true multi-disciplinary teams working in community clusters with the formulation of PCN teams – with community nursing, mental health, social care, primary care staff;
- Effective risk stratification and effective MDT working through PCNs for those who are frail/have multiple long term conditions;
- Explore the potential for co-located teams, or the creation of digitally-enabled virtual team hubs.

BSUH is also looking at the potential establishment of a specialist nurse-led ward at PRH, integrating with the system to provide step-down care.

The timeline for transformation of out of hospital services is:

2019-2020

- Develop place-based integrated models of care and agree the operating model with CCGs and providers around PCNs, informed by pilot work in Goldstone PCN and using a population health approach;
- Understand required outcomes and dependencies to achieving step up - step down and develop a plan for this;
- Decision on commissioning model around PCNs;
- Confirm the intermediate care bed plan for the city, quantifying the requirement and the location of these services.

2020-2021

- Work with local PCNs to develop patient demographic specific pathways required to integrate with integrated care 'hub' core offering;
- Agree Sussex wide strategy for delivering place based integrated care models;
- Commission agreed models, including for Anticipatory Care (using risk stratification);
- Implement mechanisms and pathways to support Step Up - Step Down delivery and performance reporting;
- Introduction of new operating model and expansion to more PCNs beyond Goldstone PCN.

2021-2022

- New models in place, integrating community and primary care services (PCNs).

Our immediate next step will be to develop and agree the long term vision and for intermediate care in line with the long term vision (detailed in the diagram below), as part of a Sussex Health and Care Partnership programme of work that is fit for the next ten years and delivers the NHS Long Term Plan.

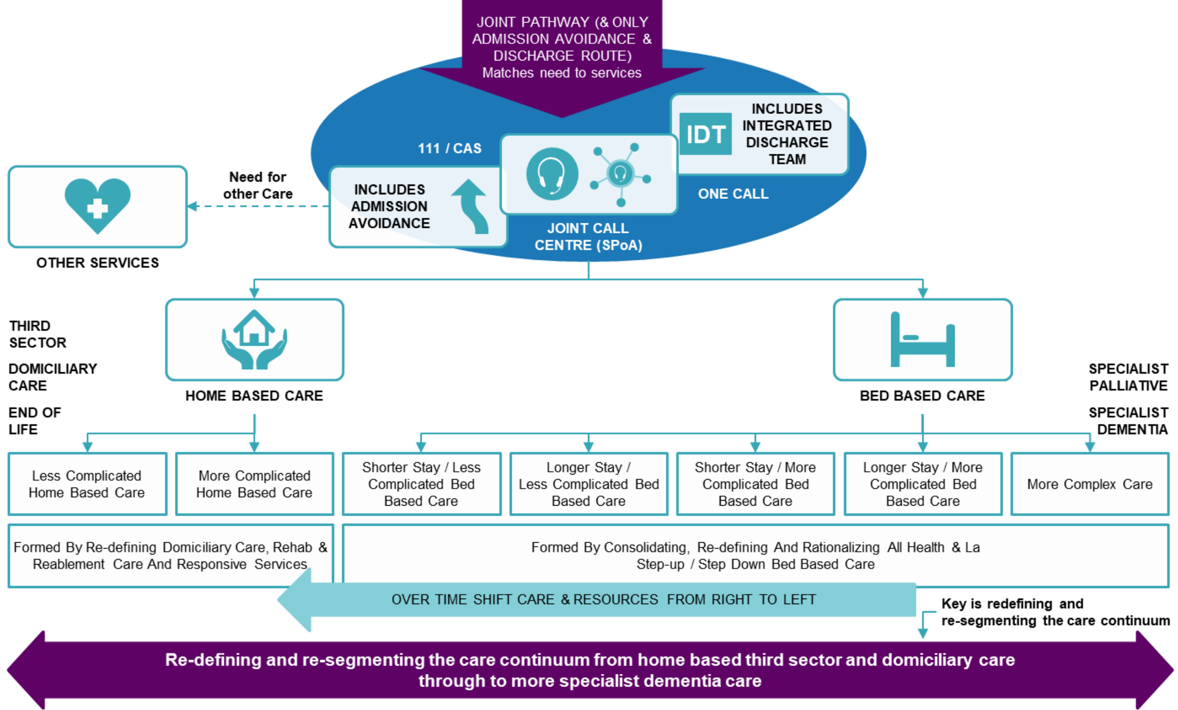


Figure 5: New model of bed-based care

Responsive community services

"I am happy that my Mum can go home from hospital. Community health and social care people have made a good plan for her care at home" Carer, daughter of an elderly patient on discharge from hospital – as told to Healthwatch Brighton & Hove

Responsive services in Brighton & Hove are delivered by SCFT, operating a multi-disciplinary team seven days a week. This service delivers:

- The rehabilitation and/or reablement of patients in their own homes or usual place of residence to achieve agreed goals related to their independence and quality of life;
- Supported discharge from acute and community beds at the earliest opportunity, with all patients who have a need for care and support upon discharge initially admitted by the service under the principle of discharge to assess;
- Avoidance of admission to acute beds – any patient with a need for urgent health or social care support to avoid their potential admission to an acute bed, and who can be cared for at home will be admitted by the hub;

- Responsiveness within two hours where clinically assessed to do so.

Work is currently being undertaken to reduce the length of stay on reablement pathways from 15 days to 7 days. This will enable additional capacity to be released and support the provision of reablement within two days.

Across the system we are also working to refresh and implement clarified, updated discharge pathways following Home First and Discharge to Assess (D2A) principles. Social work services will begin aligning with Primary Care Network localities using learning from the Goldstone PCN Integrated PCN Pilot.

Additional work is also ongoing to reduce permanent admission to care homes and support care closer to home. This includes engaging with local residents to understand what influences their ability to remain at home, using linked data to intervene earlier supported by an updated electronic care record and interoperable digital systems, optimising joint commissioning across the system through a range of different service offers, and optimising the discharge pathways from hospital to home setting.

We are developing our core offer for responsive community services and planning the following developments for 2020/21:

- A consistent service specification;
- Consistent set of KPIs/system metrics;
- Alignment of the draft responsive services specification across the entire geography;
- Ensure delivery of D2A pathway;
- Establishment of link roles within A&E to refer into responsive services;
- Expansion of Hospital @ Home model to include more pathways;
- Review of short term reablement available through PCN and community routes as well as through the acute admission and route.

We will develop a two hour admission avoidance response service, and 2-day reablement service during 2020/21 as per the NHS Ageing Well requirements.

Anticipatory care

Brighton & Hove have focused on advanced care planning, supporting the delivery of personalised care and delivering the right care in the right place at the right time. Brighton & Hove are adopting the Recommended Summary Plan for Emergency Treatment and Care (ReSPECT) process and documentation, supporting the person and clinicians to discuss in detail what matters to the person and their goals and wishes regarding their overall treatment and care.

Many local providers have completed the first phase of training for staff and Brighton & Hove have been instrumental in setting up the Kent, Surrey and Sussex (KSS) Collaborative for the ReSPECT process, supported by Health Education England. We are also working to ensure this information can be shared digitally across all partners in the care team as well as the paper copy, using other national processes as a template for our own.

BSUH have also embedded a plan to discuss preferences for future treatment and care with admitted patients after arrival as part of the clerking and initial senior review process. A treatment escalation plan has also been created within the multi-specialty health record to centralise this core information and support personalised and anticipatory care. The Second Conversation approach from the Royal College of Physicians is also being adopted to provide ongoing review and involvement of a person and those important to them to document and communicate decisions about future treatment and care.

We are looking to commission and deliver anticipatory care, including the tools needed to achieve this such as risk stratification tools e.g. Artemis.

Enhanced care in care homes

A Locally Commissioned Service for enhanced care in care homes is already in place and we will continue to progress the roll-out of the service across Brighton & Hove nursing and residential care homes. This includes consideration of the best way to adapt the service model for different types of homes.

This work is also supported by the joint NHS, BHCC, third sector and care home providers via the Care Home Programme Board, and Care Home Forum.

Between these meetings, there are several workshops and discussions between system partners and a task and finish group on communication and processes between BSUH and care home providers.

This work also connects with ongoing work to increase medicines optimisation and review. A medications review service is commissioned by the CCG to see the patient at home/care home approximately two to three weeks after a referral is made, and we plan to consider the role of pharmacists in PCNs in relation to this.

Support for carers

Supporting unpaid carers is a local as well as a national priority. We have support workers in place for each PCN to support general practice in identifying patients who have caring responsibilities and to support in updating patient records. An electronic template has been developed for use by GPs to document the person has, or is a carer, and to support referral to Carers Hub.

Using the Better Care Fund, the CCG and the Council have developed a Carers Hub to provide a single access integrated service point for the dedicated carers' services across the City, both within the statutory sector, and voluntary and community sectors. The Hub is intended to act as single point to access effective support and highlight and raise awareness of carers, ensuring the City is "Carer Friendly". A number of GP practices within our PCNs have trained their staff in actively signposting carers to the Carers' Hub.

We have a range of services offered within the Third Sector, providing a mixture of information and advice, as well as specific support including free home-based respite to enable carers to attend medical appointments. Our Adult Social Care Carer Support Workers within each of the ASC Districts/Care Clusters provide dedicated carer support interventions, and complete Care Act compliant Carers Assessments. Our carers are celebrated and supported through the Carer's festival which also aims to raise awareness of carers and their experience.

All paid carers in council commissioned services are also able to access education and training on a range of topics relevant to caring and can also complete the Make Every Contact Count (MECC) course. A Nursing Times award winning handbook called Stop, Look, Care has been developed and shared with paid and unpaid carers and forms the basis of education sessions across the city.

Jointly is a secure, approved app jointly funded by Brighton & Hove City Council and CCG which enables carers to store and share all the important information about someone they care for; it supports sharing information with professionals and across organisations.

4.3.2 Other local plans to support Ageing Well

Ageing Well service

Brighton & Hove City Council and CCG have jointly commissioned a new citywide service which will support ageing well and connect people with their communities. The service aims to reduce loneliness and isolation, promote good health and wellbeing, prevent ill health, and enable older people to remain independent for as long as possible as they age.

The Ageing Well Service provides one phone number where professionals, carers and older people can call and speak to a well-informed team member to get the information they need to ensure older people get the best from life in the city and improve and maintain their health and wellbeing.

The service is led by Impact Initiatives and delivered by a partnership of eight other local organisations, all working under a single contract.

An insight into the Ageing Well service…

"BHCCG and BHCC are jointly commissioning this in 2019/20 to draw together a range of services for our Older People. Led by Impact Initiatives, the service brings together activities, befriending, advice and support and transport to activities under one umbrella, with a single point of contact."

Jane Lodge, Head of Engagement, Sussex and East Surrey Commissioners, October 2019

Comprehensive Geriatric Assessment

We are working towards delivering a Comprehensive Geriatric Assessment (CGA) as soon as possible in to the admission process of patients at BSUH, enabled by steps we have taken to deliver acute frailty and reduce the time between arrival and CGA from a clinician with expertise in frailty. There is now an acute frailty nurse to support this work. Opportunities to support communication and collaboration between clinicians who care for those who are frail are being explored, including multidisciplinary team meetings and working across acute and community settings.

The Rapid Access Clinic for Older People also supports admission avoidance and delivers CGA on a semi urgent basis.

Multiple long term conditions including frailty and dementia

Brighton & Hove intends to be a dementia friendly city. We are investing in new services for dementia that will be operational from 1st April 2020:

1) Memory Assessment and Support Service for people living with dementia and their carers, extending the current offer to support to everyone diagnosed. Everyone will be offered:
   - Access to specialist assessment, support and review
   - A named care coordinator
   - Access to an in-house range of wellbeing interventions,
   - Specialist advice and guidance and assessment in the event of change.

   This service will wraparound PCNs and work in tandem with them.

2) Locally Commissioned Service (LCS) for dementia which offers enhanced medical review in primary care in line with best practice.

3) BSUH has a new dementia strategy in line with the Long Term Plan.

We know that in Brighton & Hove an increasing number of people are living with frailty and multiple long term conditions. A frailty working group has been established to oversee successful design, implementation & delivery of the Brighton & Hove Frailty Programme. The key purpose of the Frailty Programme is to support delivery of safe and high quality care for the complex and frail population of Brighton & Hove through designing and developing services that support person-centred and proactive care, improved quality of care and admission avoidance, by cutting traditional boundaries between primary and secondary healthcare.

Brighton & Hove GPs are already using the Electronic Frailty Index (EFI) to routinely identify people living with frailty. This is complemented by Rockwood scoring at BSUH and SCFT. Using a proactive population health approach focused on milder and moderate frailty will also enable earlier detection and intervention to treat undiagnosed disorders and reduce the rate of progression of frailty which has higher personal and system cost and quality impacts when more severe.

4.4 Dying Well

Our ambitions for Brighton & Hove are that the experiences of those at the end of their life, whatever their age, will be improved; more people will die at home or in the place that they choose, and support for families, carers and the bereaved will be enhanced.

The first steps in delivery of this priority are to:

- Bring together key stakeholders and develop a city-wide approach to improve health and wellbeing at the end of life and to help communities develop their own approaches to death, dying, loss and caring;
- Share ideas about what a citywide approach to dying well could look like and discuss how we could build a coalition of support across Brighton & Hove, culminating in a joint action plan for the city;
- Raise awareness of public health approaches to dying well including the Compassionate Cities Charter, and compassionate communities;
- Share information on what is already happening in our city and hear examples of good practice.

Provider organisations are using the Six Ambitions for Palliative and End of Life Care and the Five Priorities for Care of the Dying Person to shape local service delivery. At their heart these include:

- Recognition that a person could be or is dying, acting on and regularly reviewing this;
- Communicating this to the person, those important to them, and the wider care team;
- Involving the dying person and those important to them in decisions about their future treatment and care;
- Supporting those important to the dying person, including after the person has died, and helping anyone who had an unpaid caring role for them to live within their changed identity;
- Delivering a personalised plan of care.

Additionally, the Recommended Summary Plan for Emergency Care and Treatment programme (ReSPECT) is being progressively implemented over 12-18 month period, and BSUH plans to increase opportunities to identify those who may benefit from a Treatment Escalation Plan.

BSUH are also specifically focusing on those who may be in the last year or years of life and have built early recognition and consideration of this using tools such as Rockwood, SPICT and frequency of hospital admission in training delivered to all clinical staff and their admission process for every patient.

We are working together in the system to develop use of the Royal College of Physicians Structured Judgement Reviews (SJRs) to standardise the review of where care of those who have died went well and where it could be improved. The aim for 2019/20 is to increase the number of SJRs reporting positive scores for each phase of care and decrease where problems in care arise.

To support paid and unpaid carers, new sections on caring for a dying person and advance care planning have been written for the SHCP Stop, Look, Care handbook which will be made available in paper and digital copies by end of 2019. This information complements the education delivered in health provider organisations and aims to support a common language, and response across care settings. City-wide training sessions with carers are being developed.

Underpinning our approach to end of life is wider system working together to ensure that End of Life conversations take place at the right time to ensure appropriate and timely referral with the objective of ensuring achievement of patient and system benefits.

One Call
A scoping plan will be undertaken at the end of 2019/20 to assess the feasibility of introducing One Call in Brighton & Hove. Subsequently we will develop an end of life care referral hub to coordinate care planning for end of life care across the city between providers and including the third sector.

ECHO
We will carry out an evaluation of the case for extending the existing Coastal West Sussex End of Life Care Hub (ECHO) service into Brighton & Hove. This will be part of the One Call transformation programme.

We have agreed that development must be co-designed with key stakeholders (CCG, Hospice, Primary Care, BSUH, Care Homes, BHCC, Voluntary and Community Sector) and that close collaboration with emerging PCNs is required. It will be essential that the service retains local knowledge and is reliable, robust and sustainable. In order to implement the service locally, a workforce audit and plan will be required to ensure sufficient staffing.

We will scope the introduction of ECHO into the integrated One Call service in Q1 of 2020/21, and mobilise the referral hub and ECHO service in Q2 and Q3 of 2020/21.

5 Quality

The role for Quality is to enable all commissioned services to be of the highest quality, delivered with respect and compassion and provide a positive experience for patients and their family. Improving quality and safeguarding people is a core function for the quality team. All plans will be assessed for their impact on the quality for patients.

Quality assurance and improvement

Quality of services will be measured using the CCG's Quality Assurance and Improvement framework. This framework provides a structured approach to improving quality and escalating quality concerns using a risk-based methodology. This will enable the commissioning quality team to proactively safeguard people, using a consistent evidence-based approach. Interventions to improve care delivery will be coordinated and delivered collaboratively with system partners.

The quality team will work alongside our commissioning teams to:

- Monitor quality performance of providers against agreed standards and outcomes reported contractually – these will include all indicators relating to patient experience, patient safety (including safeguarding) and clinical effectiveness;
- Ensure there are processes and procedures in place with providers to evaluate and mitigate the impact for patients where constitutional standards are not being met;
- Carry out surveillance in line with the Care Quality Commission 'domains' (safety, effectiveness, patient experience, leadership, culture and responsiveness);
- Use the Commissioning for Quality and Innovation (CQUIN) payment framework to support local improvement;
- Undertake quality assurance visits to services where quality concerns have been identified.

Learning from serious incidents

The CCG will continue to fulfil its statutory responsibility for management of serious incidents reported by commissioned services. This will be managed by a Patient Safety Team based at Brighton & Hove CCG who provide oversight and effective management of serious incidents for all providers across Sussex. All serious incident investigations will be reviewed at a fortnightly Serious Incident Scrutiny Group.

The CCG will seek assurance that lessons learned and action plans have been embedded in practice at contractual quality review group meetings with providers. This may also be tested at service site quality assurance visits.

Infection prevention

The CCG with provider organisations will drive improvements that reduce the incidence of healthcare acquired infections. The commissioning quality team has taken a proactive approach to achieving reduction targets including the development of a two-year clinical strategy.

Infectious outbreaks can affect the delivery of local services especially during the winter period, resulting in ward or bay closures in acute and community inpatient areas and nursing homes. To manage this effectively, the CCG has agreed with health providers throughout Sussex and East Surrey a system-wide approach to managing infectious outbreaks during periods of escalation. This includes the management of influenza in and out of season. Implementation of this system-wide protocol will mitigate against risks to manage outbreak

situations. The Brighton & Hove health protection and screening form continues to provide oversight and assurance for infection, prevention and control of infectious disease.

Workforce development

The commissioning quality team will work with providers to ensure they have effective retention plans in place that focus on engaging and empowering the workforce, understanding insights such as the reasons why people leave and are taking sustainable action to retain staff.

Contractual Quality Review Meetings will receive progress updates on a number of initiatives. For example:

- Apprenticeships: Assistant practitioners, Nurse associates
- Retention: 'Best Place to Work' initiatives [supported by HEE]
- International recruitment programme

The commissioning quality team will also work closely with NHS trusts to ensure safer staffing levels are maintained through robust clinical risk assessment.

The CCG will oversee implementation of training on its handbook for care workers in Care Homes and for home carers called 'Stop Look Care'. This project won a national Nursing Times award in 2018 in the 'Care of the Elderly' category, in recognition of its support to the unregistered workforce to ensure they are competent and confident to provide high quality care. The next phase will be the roll out of a tailored core package of training and competencies, which will form a staff passport recognised in any practice setting.

During the period of the plan, the CCG will also produce a dedicated 'Stop Look Care' for mental health, which will support all the mental health commissioning programmes of work.

Safeguarding adults, children and looked after children

The safeguarding team in BHCC and the leads in the CCG holds statutory responsibilities in relation to safeguarding adults, children and looked after children within our local populations. The CCG will fulfil its statutory responsibilities by seeking assurance around the safety and effectiveness of the services we commission. This includes the requirement for providers to complete bi-annual self-assessments against an approved Safeguarding Assurance Framework and submission of quarterly exceptions reports.

The work undertaken by the safeguarding team includes taking into account national changes, influencing local activity and developments and maintaining oversight of any actions being taken to mitigate any significant safeguarding risks.

During the period of the Long Term Plan, this will include implementation of the new arrangements for 'Working Together to Safeguard Children' and implementation of improvements where needed arising from the CQC inspection undertaken in Brighton & Hove in July 2019 focussing on safeguarding of children and Looked After Children.

6. Enablers

6.1 Digital

Over the next five years, our system will be delivering on a long term digital strategy to support the care we give our people in line with the NHS Long Term Plan using the following themes of the Locally Held Care Record (LHCR), remote care and the wider digital strategy:

- Our Connected Care – giving practitioners the information they need from all the settings in which a patient is receiving care; ensuring that the patient only have to tell their story once and that their journey through the health and care system is supported by clear messaging from one setting to another.
- Transforming Outpatients - patients will 'not have to attend outpatients unless they are required to do so' by using remote care alternatives to traditional outpatient appointments.
- Our Personalised Health – giving patients access to, and control over, their own information. Patients will have greater agency in their care, allowing them to better understand their ability to take an active role in their wellbeing. It will allow patients to communicate their needs more effectively and in better time with the right care professionals allowing them to deliver their role more effectively. Examples of this will include the development of a citizen portal within the cancer space and a Personal Health Record (PHR) which will use a shared record approach, enables a citizen through a single online identity, to access their health record. Within Sussex the Patient Knows Best solution has been procured to support citizens with multiple co-morbidities.
- Children and young people's Mental Health - Our vision is to provide more responsive support for children and young people when they experience poor mental health or are in crisis. We will give them opportunities to build their own resilience supported by their families and communities, and encourage them to support and confide in one another. They will be able to access services when, where and how they choose, embracing digital and social media. Services will work closely together so that criteria and thresholds are less important than addressing holistic need in a timely way, generating good outcomes.
- Urgent Care- Clinical Assessment Service/111 service is required to deliver the NHSE mandated Integrated Urgent Care outcomes which require seamless navigation of patients through the system with as few handoffs as possible. Key features include ability to book into local services and provide advice and support to services and care homes.
- Supporting Carers -*Jointly* is a secure, approved app which enables carers to store and share all the important information about someone they care for; it supports sharing information with professionals and across organisations. Brighton & Hove City Council and Brighton & Hove CCG fund Jointly as part of the Carers UK Digital Offer.
- We will also introduce Telehealth in Care homes and the ReSPECT process.

As we deliver the LHCR across the next five years we will also support our health and social care workforce to benefit from a more integrated digital environment, including innovations in practice based on digital opportunities.

The mental health programme requires digital solutions and innovations to support delivery and we are fortunate that SPFT, our main mental health provider, is a digital exemplar. Ambitions for digital enablers for mental health delivery include:

- An online platform for CHILDREN AND YOUNG PEOPLE'S counselling and exploration of digital alternatives for how CHILDREN AND YOUNG PEOPLE'S may access support, for example at the beginning of pathways;
- An exploration of digital alternatives to expand IAPT more quickly and meet demand, for example through SilverCloud;
- Read across with community and suicide prevention workstreams through apps, MindDistrict, video consultations, discharge plans across multi-agencies etc;
- Development of booths within A&E to talk to a mental health specialist in a phased approach from 2022/23.

For Community Services, SCFT are investing in digital across the Trust and have nearly completed a full roll out of the electronic patient record system for all services, with an anticipated completion at the end of March 2020. In addition, e-prescribing and virtual clinics will be implemented over the next few years.

Key digital enablers being implemented at BSUH include Order Comms investigation requesting, electronic observations, and (as with SCFT), e-prescribing.

Partner organisations, including at PCN level, are focusing on increasing the number of health and social care professionals with access to Summary Care Records (SCR), and discussing with patients to increase receiving consent for the enhanced SCR which provides vital information to support collaborative working across organisational boundaries. Digital enablers for PCNs and GP practices also include GP digital dictation and online consultations as a new model of care to release capacity.

6.2 Estates

Across our CCG footprint we continue to have a number of primary care estate challenges which are exacerbated by ongoing local population growth. These include the size of the premises in relation to the registered population and the layout and the condition of the buildings, all of which can seriously impact on care delivery in various ways.

We have been working with our GP membership to assess the suitability of our primary care estate across our footprint. We have undertaken a prioritisation process, to enable us to see which practice developments should be regarded as most urgent and/or important.

The CCG is taking forward a significant number of primary care developments simultaneously to ensure that practices and Primary Care Networks have the capacity and are well placed to deliver the additional services required going forward, including additional PCN services, integrated community hubs, new digitally enabled ways of working and increasing outreach services from secondary care.

In terms of acute estate, BSUH is in the process of rationalising their clinical estate to make the future configuration within the 3Ts development more streamlined and efficient than the current configuration of services, with Stage 1 and 2 of the programme providing the largest opportunity for addressing this. This development will also create significant new and much needed bed capacity for future demand and need.

The Brighton General Hospital will also be undergoing redevelopment to bring mental health services, community care and primary care into one building for East Brighton services. Currently services are spread over approximately 20 buildings, on a large site with very steep gradients, presenting considerable physical barriers in terms of access. The redevelopment is expected to bring significant benefits including improved accessibility due

to single-level access, improved team integration for more joined up patient care, enhanced healthcare for an area of the city with some of the highest rates of deprivation and a modern fit-for-purpose healthcare facility which will attract and retain staff for the future.

6.3 Workforce

It is widely understood that we are operating in a challenging environment in terms of resources to meet the needs of the population and this is particularly true with regards to the current and future workforce. It is vital for us to work together to ensure we have a sustainable workforce to deliver our plans now and in the future to care for our population.

In order to achieve this in the context of the financial resources available, we must implement a range of solutions to maximise recruitment and retention. At BSUH, interventions as part of the emerging integrated workforce development plan will include:

- Pathway redesign to free up existing staff time;
- Improving workforce resilience through the Leadership, Culture & Workforce programme;
- Workflow redesign to ensure optimal matching of people and activities;
- Consideration of outsourcing, insourcing and cooperation with partners across networks;
- Recruitment to posts where this is financially sustainable.

To mitigate the key underlying risk to delivery of plans for mental health services, a dedicated workforce group has been developed at a Sussex-wide level to undertake workforce modelling to help forecast workforce and recruitment pressures across the mental health workstreams, and they have also implemented several new roles into this workforce including peer workers, graduate mental health workers, non-medical prescribers, nursing associate and non-medical Responsible Clinicians. In addition to the overall Sussex-wide impact, this work will benefit Brighton & Hove patients.

As well as this, it is important that we ensure optimal partnership with the community assets present within the city. The Community and Voluntary Sector has a robust workforce underpinned by a wealth of experience and expertise and this is a significant opportunity for the mitigation of the workforce limitations within NHS partners both in the short-term and also in the longer-term as current CVS volunteers may choose to pursue careers in health and care as a result of their experiences/Clinical Shadowing programmes aiding future recruitment and diversifying the workforce to enrich it.

At a system-wide level, a transformation workstream is in place to bring partners together, including the NHS and the CVS, to establish the future principles for working together. This will include place-based discussions to ensure local groups and services are fully involved.

Reference documents

The following documents are also available as contextual references to this plan:

- Brighton & Hove Response to the Long Term Plan Briefing Cover Sheet
- The Brighton & Hove Joint Health and Wellbeing Strategy
- Several Joint Strategic Needs Assessments – particularly:
  - Brighton & Hove Joint Strategic Needs Assessment 2019
  - Multiple Long Term Conditions 2018
  - Ageing Well 2018
- The NHS Long Term Plan (published January 2019)
- The NHS Long Term Plan Implementation Framework (published June 2019)
- South place staff response to the NHS Long Term Plan (CCG, Public Health and local authority commissioners)
- Partnership Guide to Integrated Care Partnerships (ICPs) in Sussex
- *Our Population Health Check*

Advancing our health: prevention in the 2020s – consultation document

Appendix 1: DRAFT population health outcome measures for the Joint Health and Wellbeing Strategy

	Proposed JHWS indicators
Overarching	• People will live more years in good health (reversing the current falling trend in healthy life expectancy) • The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced
All ages	• The percentage of the population who travel actively is increased • Hospital admissions for violent crime? • Homelessness/ housing (TBC) • Percentage of deaths due to particulate air pollution?
Starting well	• The gap in having a good level of development at end of reception between pupils eligible for FSM and other pupils is reduced • The high rates of – Smoking – Alcohol and – Drugs use in 15 year olds are reduced • Educational attainment at 16 is improved for all pupils and those from disadvantaged groups • The percentage of pupils who often/sometimes feel happy increases OR often/sometimes worry about the future decreases • Immunisations (MMR two doses by five years)
Living well	• The gap between the overall employment rate and the rates for those with long-term health conditions, learning disabilities and in contact with mental health services are reduced • The percentage of adults with high levels of happiness is increased and with high levels of anxiety is reduced • The percentage of physically active adults (i.e. who undertake a minimum of 150 minutes of moderate physical activity per week) is increased • The adults smoking prevalence, and the gap between routine and manual workers and other groups, are reduced • Alcohol related admissions to hospital are reduced • Drug related deaths are reduced • HIV 95/95/95 (95% of all people living with HIV know their HIV status; 95% of people with diagnosed HIV infection receive sustained antiretroviral therapy; 95% of people receiving antiretroviral therapy with have viral suppression) • The percentage of cancers detected at an early stage is increased • Deaths from suicide and undetermined injury are reduced
Ageing well	• Health related quality of life for older people is increased • Good quality of life for carers is increased • Repeated admission to hospital is reduced • Hospital admissions due to falls are reduced • Permanent admissions to residential and nursing homes are reduced - indicator development required
Dying well	• People dying in their usual place of residence • Local indicators to be developed in the first year