Brighton and Hove Clinical Commissioning Group

Operating Plan 2016/17

Contents

1. Introduction and Background 3
1.1 Introduction 3
1.2 National Context 3
1.3 Working with Patients, Carers and the Public 4
2. Local Strategic Context 5
2.1 Adult Social Care 5
2.2 Brighton and Hove Joint Health and Wellbeing Strategy 2015 5
2.3 Our Population 6
2.4 Joint Strategic Needs Assessment 6
2.5 Right Care Approach 7
3. Local Financial Context 7
4. Delivering the NHS Constitution 8
5. Our Commissioning Plans for 2016/17 10
5.1 Clinical Delivery Model 10
5.2 Person at the Centre 11
5.3 Transforming Primary Care 12
5.4 Responsive Community Services 14
5.5 Safe and Effective Hospital care 16
5.6 Transforming Cancer Care 18
5.7 Improving Mental Health 18
5.8 A Good Start 20
5.9 Medicines Management 22
5.10 Information Management and Technology 22
6. Quality and Patient Safety 23
7. Governance and Assurance 26
8. Conclusion 27
Appendix 1 – Risk Register 29
Appendix 2 - Glossary of Abbreviations 30
Appendix 3 – Summary of Plan 31
Appendix 4 – Gantt Chart 32

1. Introduction and Background

1.1 Introduction

The Brighton and Hove Operating Plan 2016/17 describes how the CCG will deliver the vision outlined in the Brighton Clinical Strategy and is set in the context of the emerging themes of the Sustainability and Transformation Plan.

The Brighton and Hove Clinical Strategy describes how as system leaders the CCG will deliver rapid recovery and a sustainable future model of care that addresses 3 key gaps identified by the 5 Year Forward View – in terms of health, quality and finance. The Strategy defines Brighton and Hove's CCG's vision for improvement and sustainability for our local health system, and aligns with the direction and purpose of our neighbouring CCGs' strategies and plans for the catchment of our local trust (BSUH).

The CCG Clinical Strategy provides a coherent strategic framework from which our more detailed local implementation plans, which are evidenced in this annual operating plan, are developed.

Our vision is to radically transform the local model of healthcare from one that is reactive, bed based and generally delivered in crisis, to one that is more person-centred, proactive, preventative and built on the foundation of sustainable and high quality general practice and truly, integrated partnership working.

Our aim is to strengthen integration between:

- health and social care services;
- primary and secondary care services;
- mental and physical health services;

to improve health outcomes and increase the quality and efficiency of services.

During 2015/16 the local health economy has faced significant performance challenges. Access to emergency care services has been below the required standards and patients have faced long waits for planned care services. Improving the performance against key national and local targets is of paramount importance to the CCG. As such, our plans focus on the dual themes of delivering short term recovery whilst laying the foundations for the longer term models of care which will ensure sustainable delivery of high quality health and care services in the future.

Fundamental to developing this plan has been an in depth analysis of our current performance in terms of both spend and outcomes. This has allowed us to target resources to those areas of the highest need and those that will deliver the highest impact. The plan has also been shaped by the national guidance including the Five Year Forward View: Shared Planning Guidance and the NHS Mandate.

1.2 National Context

NHS England and independent analysts have calculated that a combination of growing demand and flat real terms funding would produce a mismatch between NHS resources and patient needs of nearly £30 billion a year by 2020/21.

This scale of challenge cannot be met by efficiencies alone and the expectation is that transformational change will support the delivery of this ambition. The change needed is described in the national planning guidance: NHS Mandate and Five Year Forward View Shared Planned Guidance, which are summarised below.

NHS Mandate

The Government's NHS Mandate 2016-2017 sets out the budget, objectives and expected deliverables for the NHS in both the short term, with details of specific outcomes for 2016-2017 and staged through to 2020. It outlines the objectives and goals for the NHS in delivering sustainable improvements in care, outcomes quality and equity of access for patients as well as the expected engagement with new technologies and achieving financial security. The Mandate for 2016-2017 makes clear the commitment to a multiyear budget and planning programme which supports NHS England's and the CCGs delivery to 2020. The requirements of the mandate form the backbone of this operating plan.

Shared Planning Guidance

The Five Year Forward View Planning Guidance sets out the priorities for local and national NHS organisations for 2016/2017 and the expected scale and pace of delivery of change and services forward to 2020. The guidance highlights the expectation that all NHS developments must be based on three deliverables:

- The implementation of the Five Year Forward View
- Restore and maintain financial balance
- Deliver core access and quality standards for patients.

The Planning Guidance further states the CCG Operating Plans for 2016-2017 should be ambitious in the visioning and implementation of new models of care, promote engagement with new technologies and focus on supporting actions to drive clinical priorities. In developing the Operating Plan for 2016-2017, the CCG have used this guidance as a template to articulate credible and far reaching plans, initiating the progressive steps towards working with other organisations to facilitate the goal of place-based planning and the associated governance to assure the success of this.

Sustainable Transformation Plan

As described above, the delivery of a sustainable, transformed NHS, which is place based and facilitates commissioning and integration across all services, is dependent on the development of a credible, ambitious sustainable transformation plan (STP).

Work on the Sustainable Transformation Plan is well underway. The Sustainable Transformation Plan submission to NHS England in early April 2016 defines the geographical and provider footprint for the STP. The footprint covers East and West Sussex and East Surrey and is comprised of 23 partner organisations including commissioners and providers and health and social care organisations. The footprint covers service provisions for a population of two million people which includes pockets of severe deprivation and substantial health inequalities

A programme board has been formed, with established Terms of Reference, and meets fortnightly. The Board membership includes the Chief Officers/ Chief Executives of all partner organisations, representatives from 4 county councils and GP representatives. The Urgent and Emergency Care Network (UECN) share their footprint with the STP area and the chair of the UECN is a member of the STP Programme Board. This will facilitate coordination and planning and provides opportunity to drive improvements in Urgent and Emergency Care at pace. Decisions at Programme Board will be reached by discussion and consensus.

To support the initial phase of framing the problems, sub-groups have been formed and tasked with defining the performance gaps: Health and Wellbeing is led by the local Public Health leads, Care and Quality by partner quality leads and Finance and Efficiency by partner Directors of Finance. Healthwatch will be invited to attend so the views of the public and patients are well represented at this level. For further details please see the Sustainable Transformation Plan.

1.3 Working with Patients, Carers and the Public

In addition to using the above guidance as a planning framework, the CCG has also developed our plans with extensive engagement with patients, carers and the public. Over the past year, the CCG has built on existing work to engage with patients, carers and the public to ensure we achieve our aim that patients and their carers are at the heart of the CCG's work. The means to achieving this is described in our Patient and Public Participation Strategy.

To support the delivery of the Patient and Public Participation Strategy the CCG has established the Participation and Communication Assurance Committee (PARC), a sub-committee of the Governing Body. This committee has a role in assuring the Governing Body that we hear and act on the voice of local patients and their carers. It is chaired by the Governing Body's Lay Member for Patient and Public Participation. The membership of the group includes the Community and Voluntary Sector, Healthwatch, Public Health and an elected member from the PPG Network whose role includes bringing issues from the Network to PARC.

We have continued to build our Patient Participation Groups in each GP practice, supported by Community Development organisations through a commission overseen by Community Works. This expertise enabled the development of groups and supported our GP practices to understand and appreciate the potential of a Patient Participation Groups. We continued to develop the Hangleton and Knoll Health forum, which incorporates 4 PPG's and takes a community based approach to looking at primary care and community support in this

discrete geographical area. We have awarded 10 small grants to PPGs in the city this year, against criteria to further develop PPGs, link with local communities and support community approaches to health and wellbeing.

We have carried out engagement for many of our clinical work streams through the year; one highlight was the work we carried out, with support from the National Commissioning for Better Patient Experience programme, on support for those who have lived with, or continue to live with, cancer after active treatment ceases. A number of peer researchers gathered the views and experiences of cancer patients and survivors, and worked in collaboration to pull out key themes and develop solutions for future action.

In late 2015 the CCG and Healthwatch commissioned a community engagement specialist to engage with seldom heard groups and individuals. We heard from over 750 individuals whose responses provided insight into views and experiences of accessing and using primary care. The work helped us understand the barriers to people looking after their physical and mental wellbeing.

During 2015 we worked with local people with complex conditions and their carers to collaboratively develop Person Centred Outcome Measures. We used these insights to develop "I statements" based on what is important to these individuals and their carer's. We are currently trialling the use of these measures in person centred care planning within our proactive care teams.

2. Local Strategic Context

2.1 Adult Social Care

Financial pressures are challenging the scope and means of delivery of adult social care services for Brighton and Hove. Adult Social Care are identified to deliver £7.14 million savings for 2015-2016 and are anticipating delivery of further savings of £21.9 million by 2020.

Further enhancement of partnership working with the City Council will progress the integration of health and social care services, mental health services and children's health services to ensure we are achieving the best value for money from the public purse and to deliver better outcomes and improved experiences for our population.

The Brighton and Hove's City Council's vision going forward to 2020 includes:

- Signposting- information and advice to enable people to look after themselves and each other and get the right help at the right time
- Stronger communities- help people to build support networks by working in partnership with local health and community services
- Getting people on the right track- preventative services that help people stay independent for longer and support them to recover after illness
- Citizens will be in control of their own care- when people do need extra care and support, services will be personalised and joined up around individual needs

This vision aligns with the direction of the CCG plans and the work to progress this has already commenced and will continue through 2016-2017 year. The challenges and aspirations both organisations face going forward to 2016-2017 will foster greater and more efficient integration and joint working on programmes. Services separately commissioned by the CCG and the Council have been similar in the past and closer working will avoid this in the future and deliver efficiencies.

The ambitions for the diverse population of Brighton and Hove are the same across the organisations; a desire to promote and improve wellbeing in individuals and support them in actions to prevent them becoming unwell. For those who are in need of support and help in living we will commission services that will support independence, personal choice and control.

2.2 Brighton and Hove Joint Health and Wellbeing Strategy 2015

The draft Brighton and Hove Joint Health and Wellbeing Strategy (JHWS) 2015 outlines the health and wellbeing goals for the people and communities of Brighton and Hove City. The strategy aims to improve the health and vitality of the Brighton and Hove population and communities while also striving to reduce the inequalities that exist within it. These goals will be progressed through a multiagency, cross sector approach

which will deliver a range of plans across the city over the next 5 years. The JHWS is to undergo further development in response to the forthcoming outcomes reported by the Fairness Commission in summer of 2016. In addition, baseline data for a number of initiatives cited in the strategy is being gathered. The final iteration of the Health and Wellbeing Strategy will be published in summer 2016.

The JHWS is based on a partnership approach which recognises the contributing influences on health and inequality; these include education, housing and employment. Further to this, the strategy partners acknowledge these change ambitions are being initiated in a time of financial constraint. In response, partners in the strategy have agreed the need to "pull the resources together- not only money but staff, buildings and resources- to ensure that together we maximise the impact of what we already have". JHWS priorities identified for the population of Brighton and Hove are summarised below.

- Reducing Inequalities across the city
- Safe, Healthy, Happy Children, Young People and Families
- Provide each individual the chance to live and age well
- Develop Healthy and Sustainable Communities and Neighbourhoods
- Provide Better Care Through Integrated Services

2.3 Our Population

The population of Brighton and Hove is distinctively different from that of most cities in England, it has lower proportions of people aged between 65 and 74 years old and children, and a higher proportion of adults aged between 19 and 44 years old. There is also an unusually high proportion of students and Lesbian Gay Bisexual Trans (LGBT) residents. This type of population is classed as a 'Sphere population' in the NHS Atlas of Variation, and is seen in only 20 cities in England.

The City currently has approximately 281,100 residents, with an equal male to female ratio. The life expectancy for females (82.6 years) is higher than that of males (78.5), and the main all-age mortality causes are similar for both. Males experience a higher proportion of deaths due to external causes, and emergency hospital admissions.

It is estimated that the LGB communities account for 15% of the Brighton and Hove population, and there are approximately 2,760 transgender people residing here. LGBT residents have an increased risk of mental disorders, homelessness and domestic violence.

According to the latest census in 2011, White British people account for around 80.5% of the city's population, and 19.5% identify as BME. One-quarter of births within the city are to mothers who were born outside of the United Kingdom, and 8.3% of people over 3 years old do not have English as their primary language. BME residents tend to have a lower uptake of services due to a multitude of factors, including lack of cultural awareness within service delivery, and difficulties in access. Migrant residents have a higher prevalence of infectious diseases and a lower uptake of cancer screening.

There are an estimated 17,400 military veterans residing in Brighton and Hove, the majority of which are male. This is an important sub-group of the population to consider due to their increased risk of mental illness, limb loss and musculoskeletal disorders.

Around 9% of the city's population identify as carers, and it is estimated that around 2,000 a year will need treatment for stress-related illness or physical injuries sustained through their role.

There are currently 34,335 students registered with the universities of Brighton and Sussex. This sub-group have increased need for mental health, sexual health and alcohol and drug misuse services. Students account for over 10% of the local population, and a proportion choose to stay in the city after graduation each year.

2.4 Joint Strategic Needs Assessment

The CCG identify health and social needs by working with public health staff to develop the Joint Strategic Needs Assessment (JSNA). The JSNA enables us to understand the different needs of people in different areas based on factors such as the age structure of the population, socio-economic status, ethnicity, and access to health services which are all associated with particular health risks. It also identifies areas where we are doing well and those which need improvement.

The JSNA identifies the following key health and wellbeing issues in the City:

- Increasing rates of limiting long term illness: The majority of people aged 75 years and over in Brighton & Hove live with a limiting long term illness, as do a significant proportion of those aged under 75 years (38% of males aged between 65-75 years);
- Social isolation and relationship with health: Brighton & Hove has a relatively large proportion of older people living alone and potentially isolated who are more dependent upon public services. Single pensioner households are higher than average and the majority of people aged 75 or over live alone; of those living alone, 34% are male, 61% female;
- High levels of mental health & substance misuse (drugs and alcohol): The City has almost twice the national suicide and undetermined injury death rate in older people. 13% of adults have a common mental health disorder while 1% has a more severe disorder. Both of these rates are higher than average levels. 18% of adults in the city are believed to engage in increasing or higher risk drinking. Rates of alcohol-related A&E attendance and hospital admissions have increased in recent years. In addition, the city faces challenges from substance misuse.
- Homeless: We have increasing levels of homeless and housing pressure. We have seen homelessness increased by 38% over the last three years. There is a huge inequality in terms of morbidity and mortality; the average age of death of a homeless man living on the streets of Brighton is 47 years compared with an average of 77 years for the population of Brighton as a whole. The JSNA estimates that the homeless population A&E attendance rates are 5x higher than B&H average.
- Cancer Outcomes: 1200 of people in Brighton and Hove are diagnosed with cancer annually, predicted to rise by 2% annually. In Brighton and Hove the 2012-2013 Royal College of General Practitioner's cancer audit showed:
    - 10% of cancer diagnosis were made through the emergency route
    - One third of cancers with a recorded stage are diagnosed at a late stage
    - High levels of deprivation are associated with lung cancer which has the poorest prognosis
    - 17% of cancers in the East of the city were lung cancer compared with 12% of all cancers in the rest of Brighton
    - Unacceptable delays in the pathway from primary care and secondary care and to first definitive treatment.

2.5 Right Care Approach

The Right Care approach brings together a variety of evidence sources to optimise and target commissioning and maximise value.

Brighton and Hove CCG has adopted the Right Care approach in the development of this plan. A high level summary of the evidence from Right Care, Commissioning for Value and Atlas of variation is outlined below.

There are 5 conditions/areas where the outcomes for patients in Brighton and Hove are significantly worse than our peers: musculoskeletal (MSK), diabetes, respiratory, circulation and mental health. The CCG have started to address the poor outcomes in these areas. During 2015/16 a new MSK service was implemented, the CCG procured a new diabetes service and reconfigured the city's respiratory services. Our plans for 2016/17 include further development of our plans for circulation and mental health conditions.

There are 5 areas where we spend significantly more than our peer CCGs: trauma and injuries, mental health, neurological conditions, cancer and circulation. Additionally Brighton and Hove CCG have four key areas where we spend more and have worse outcomes than our peers: trauma and injuries, mental health, diabetes and circulation.

Using the evidence collated as part of our JSNA and Right Care we have developed a list of clinical priorities from which we have derived the programmes for 2016/17.

3. Local Financial Context

Brighton and Hove CCG has consistently achieved a surplus above the required 1%. In 2015/16 the CCG will post a surplus of £12.6m (3.4%). The requirement in the planning guidance is for the excess surplus to be drawdown by the CCG over the next three years.

The CCG is deemed to be overfunded under the weighted capitation formula in 2016/17. Moving into 2016/17 the CCG has moved closer to its fair shares target. This exerts a financial pressure on the CCG as it has received no real terms growth and this will be the case over the next five years. Even with the restriction on growth of the CCG allocations the CCG remains at c4.5% over funded.

The lack of real terms growth makes it difficult for the CCG to progress the transformational changes were it not for the ability to drawdown £9m of our carried forward surplus over the next three years. To do so will require the production of robust business cases to NHS England. These are also a requirement of our internal planning process and CCG governance. As a planning assumption we are assuming NHSE agree to a £3m drawdown in 2016/17. This will take the CCG surplus control total for 2016/17 to £9.7m (2.6%).

The plans for 2016/17 commits none of the (now) 1% Non-Recurrent reserve. This is in line with planning guidance but we will need to allocate these funds during the year on items such as the transitional support to BSUHT for the implementation of 3T's once the transitional costs are determined. In previous years we have maintained the recurrent/non-recurrent split at 98% recurrent and 2% non-recurrent but have now moved to the minimum requirement of 1% non-recurrent reserve. This is part of the medium term financial plan and assists the CCG in coping with the lack of real terms growth.

The plans contain a 0.5% contingency reserve as required in the planning guidance financial rules. The overall framework will be challenging for the CCG given the context of our distance from target and the resultant restriction on growth.

The CCG has set a QIPP efficiency savings target at 2.6% (£10.0m), which currently includes £4.6m of unidentified QIPP savings, which increases the challenge to the health and social care system. The planning guidance encourages joint working with the City Council, the Better Care Programme Board and partners across the whole health and social care system. The CCG plans are being developed with partners and providers in the context of a wider strategic planning footprint. The CCGs have, historically, a good working relationship in relation to planning across the Sussex area. The national planning guidance recognises that this scale of planning needs to develop and continue to deliver the changes set out in the Five Year Forward View. This joint working will be evidenced during 2016-2017 though the development and delivery of Sustainable Transformation Plan.

Once we have finalised our income and expenditure plans for 16/17, we will undertake a full risk assessment and begin the task of identifying further savings initiatives. We will also review all investment plans with a view to scaling them back to meet the currently unidentified QIPP savings target and bring plans within the funding available.

Contractual Approach

Our contractual approach for 2016/17 builds the foundation for future models of care by moving away from traditional activity based contracts to outcomes and pathway commissioning. During this transitional year we will use all of the contractual levers available to us to drive improvements in quality and delivery of standards.

4. Delivering the NHS Constitution

The NHS Constitution establishes the principles and values of the NHS in England; it sets out the legal rights of patients, public and staff, the further pledges the NHS is committed to achieve and sets out the responsibilities of public, patients and staff.

We are committed to meeting the obligations and expectations placed upon the CCG by the NHS Constitution. We will do all we can to promote patient rights, address concerns where these are brought to our attention and support our providers in doing the same.

Whilst historically we performed well in delivering NHS Constitution standards and key national performance indicators, we have recently seen deterioration in a few key areas. In response to this we have strengthened our programme and performance management approach, made a clear commitment to use the contractual levers at our disposable and worked collaboratively with the local health and care economy to develop credible and deliverable plans. The sections below provide a high level summary of each of the recovery plans:

4 Hour A&E

Our previous plans failed to improve the achievement of the 4-hour operational standard. However, the improvement in the unscheduled care performance remains of the highest priority for the CCG, the Brighton and Sussex University Hospital (BSUH) Trust and for the local health economy. In line with the tripartite discussion in April 2016, the Trust has agreed an attainment of 89% against the A&E standards by September 2016. Section 5.6 outlines the plans which underpin this improvement. The plan is overseen by a Joint PMO and the Systems Resilience Group and has delivered improved A&E performance compared to last year.

The poor A&E performance has had a knock on effect on ambulance handover times. Whilst ambulance handover delays decreased in the second half of 2015/16 maintaining this target will remain a high priority. The Acute Trust is currently working up Ambulance Handover Trajectory for 2016-2017 for agreement at the next System Resilience Group.

Referral to Treatment (RTT)

Demand for planned care services from GPs has reduced this year. However, during this period, referral to treatment performance has been significantly challenged at our local acute trust. Detailed analysis of referral data has shown significant increases in referrals from consultants and other sources such as allied health professions and dentists. There has also been increasing levels of two week wait referrals.

The CCG are supporting general practice in making informed decisions with the patients through providing monthly updates of waiting times by specialty. Additionally the referral management service identify alternative providers and provide patients with appointments with these as a default position for all new outpatient appointments in specialities with long wait times.

We have worked with our local acute provider to model the available capacity and recognise that additional activity will be required to reduce the existing backlog and return to a system where demand and capacity are matched.

In order to meet the existing level of demand, we have commissioned 3% more new patient pathways per month. In addition, we have commissioned 4% more activity to ensure that those patients already on a waiting list are treated in 2016/17. The CCG is seeking to commission new capacity with local independent sector providers. This will improve patient waits and reduce pressure on the acute trust. Section 6.6 outlines the plans which underpin the delivery of this extra activity.

Diagnostics

Key to the delivery of the RTT standard is the diagnostic waiting time target of 6 weeks. During 2015/16 a validation exercise highlighted that a proportion of the diagnostic waiting list was not being correctly reported and resulting in a backlog of patients waiting for echocardiograms. Significant additional activity has taken place in recent months to reduce this backlog.

Demand and capacity modelling has highlighted some areas of concern in 2016/17. These are primarily related to endoscopy (digestive diseases) and increased diagnostic activity as a result of implementing the new NICE guidelines for cancer. We have included in our contracts for 2016/17 the additional activity required to accommodate these changes.

Cancer Access

Historically the CCG performs well on cancer access targets, however, we recognise that the number of two week referrals has increased this year and, as result of new NICE guidelines, is forecast to increase further in 2016/17. In light of this and in response to the national Cancer Taskforce Call to action the CCG and public health partners have developed a Joint Cancer Strategy, This Strategy provides a transformational framework for the diagnosis, treatment and care for people affected by cancer in the city. The approach addresses all components needed to deliver a gold standard service in the city.

A number of specific projects are being developed and implemented to support the strategy ambitions. These are detailed in section 6.6 and collectively evidence our commitment to improving and transforming the experience of those whose lives are touched by cancer.

Mental Health Access Targets

The new waiting time standard requires that 75% of people with common mental health conditions

referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral. These targets have been monitored throughout 2015/16 and our local IAPT provider is meeting both.

In addition to these new targets the services will continue to be required to maintain the access standard of ensuring that at least 15% of adults with relevant disorders will have timely access to IAPT services with a recovery rate of 50%. The CCG have consistently achieved the coverage element of this target but have struggled to deliver the recovery target; the eligibility criteria of our local service make delivery of this target more difficult. In response the CCG, is recommissioning the service in 2016/17 to ensure delivery of the required standards.

The expectation is that the new service provider will meet all national standards for IAPT services and this expectation has been clearly set out within the procurement process. The CCG have taken into account the ambition to reach 25% access to IAPT by 2020 in its re-procurement of the IAPT service. The Memorandum of Interest (MOI) which has recently been published as part of the procurement documents states the CCG's intent to commission a service that can provide 18% access within the first full year of operation (2017-18). The CCG has also made it clear that the new service will need to be responsive to changing national standards in relation to access, with an expected rise to 25% by 2020.'

NHS England has identified a 50% recovery rate as a required standard outcome for IAPT services. Brighton and Hove residences who meet the service access criteria tend to have a high acuity. We will continue to work with the existing provider and the provider of the new contract from 2017 to secure delivery of the national target to meet the recovery rate for IAPT.

Brighton and Hove CCG has invested additional money with the provider of Early Intervention in Psychosis service in 2016/17 to ensure they could achieve the access targets by April 2016. They are currently achieving the access targets and will be regularly monitored against these. A service specification has been agreed and a Service Development Improvement Plan (SDIP) will commence in 2016/17 which builds on the SDIP implemented in 2015/16. The CCG will to continue to monitor on-going service improvements.

5. Our Commissioning Plans for 2016/17

5.1 Clinical Delivery Model

Our strategic vision and clinical priorities translate into a model of transformation and care delivered through 5 interdependent elements (Responsive community services, Safe and effective secondary care, Communities of practice, Proactive/ preventative care, Reablement and Rehabilitation and) with the patient at its core, as highlighted in figure 1. The model illustrates our ambition to move from expensive, institutional and impersonal care, exemplified by inequality, disease burden and inefficient use of resources, to a sustained, resilient and healthy population with increased independence and wellbeing and efficient services. The diagram below illustrates the clinical delivery model which we believe will ensure our vision is realised.

Central to this is prevention through the active empowerment and engagement of patients and communities. People will thus have more choice and control and more ability to care for their own health.

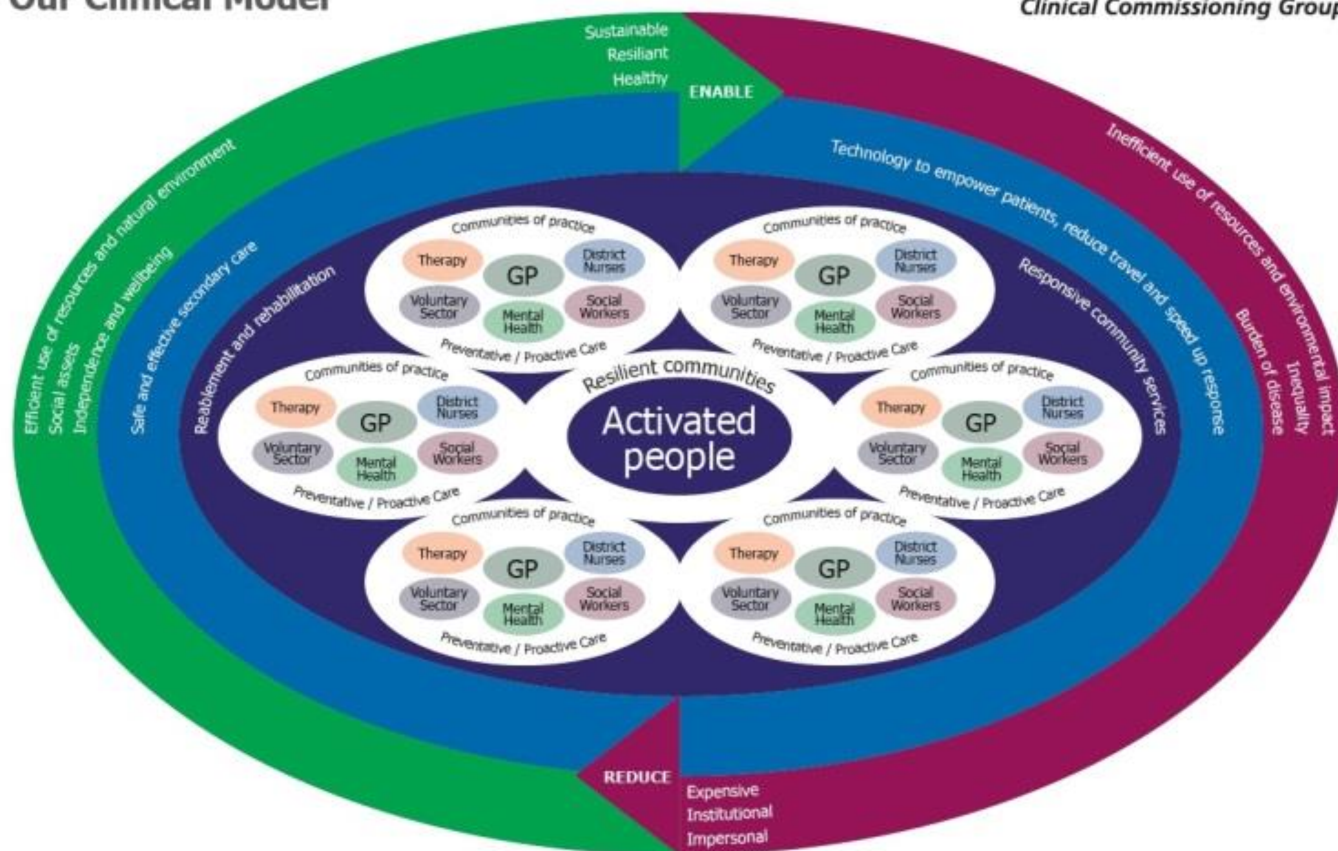


Figure 1: Our Clinical Delivery Model

5.2 Person at the Centre

The individual is at the core of our clinical delivery model and is the starting point for the development of an embedded ethos of proactive self-managed care with a focus on prevention and maintenance of independence.

Fundamental to this shift in focus, and the development of the empowered and engaged patient, is the establishment of a more collaborative model of General Practice and aligning/integrating community resources to deliver more joined up health and social care and preventative proactive support services. The patient centred vision of our clinical strategy is intended to improve the person's lifelong health pathway, support patients to have choice and control and to reduce the power imbalance between patient and service provider.

The following sections describe how we will start to deliver the clinical model in 2016/17. Our plans are summarised in Appendix 3.

Activated People

'Patient activation' is a concept that refers to the engagement of the individual in the knowledge, skills and confidence in managing their own health and health care. People who have low levels of activation are less likely to play an active role in staying healthy. They are less likely to seek help when they need it and less inclined to follow doctor's advice. Further these patients are perceived to be reticent at managing their health when they are no longer being treated.

The CCG has developed a self-management strategy that supports and encourages people to manage their own health, to stay healthy, self-manage their conditions and avoid complications where possible. In 2016/17 we will further progress this agenda by:

- completing a mapping exercise of voluntary/ community sector and self-management/peer support resources and assimilate this information into local My Life information portal for the city

- ensuring promotion of self-management through primary care cluster proactive care working (care coaches/navigators)
- utilising the CCG Locally Commissioned Services (LCS) framework to explore opportunities for a small number of projects for the self-management of long term conditions consistent with CCG objectives and JSNA priorities such as hypertension and obesity
- supporting the effective promotion of self-care personalisation initiatives such as Telecare/Living Well and Carers support projects across primary and community services
- working with Sussex Community Trust to ensure that self-management is embedded across specialist and generalist community services and integrated into care pathways; and to review the introduction of local Telehealth initiatives.

Personal Health Care Budgets

The CCG actively supports the continued rollout of personal health care budgets for individuals as a factor in the delivery of a personalised agenda for care.

The CCG already have a number of clients, funded under NHS Continuing Healthcare, who manage their own care packages, either by a direct payment or with a third party managing the budget. The CCG are working to extend this approach to a wider client group.

During 2016-17 the CCG will continue to offer the 'right to have' a personal health budget to all people eligible for NHS Continuing Healthcare and to families of children eligible for Continuing Care. We will develop a local plan that will confirm the extension of the personal health budget (PHB) offer to other care groups beyond Continuing Healthcare in 2017-20. Effectively delivery of this ambition is dependent on working with social care, NHS providers and the local voluntary/community sector to identify cohorts of people who may benefit from a PHB. This will include the following care groups:

- People with long term conditions including mental health
- People with a learning disability (within the Transforming Care programme)
- Children with complex needs.

By autumn 2016 we will confirm the approach to budget setting across these agreed care groups. This will provide consistent clarification to individuals on the amount of their PHB. The CCG will develop structure and guidance to enable individuals to exercise choice and control over how the budget is used and what mechanisms are in place for payment. These options include:

- National PHBs- where the budget remains within the NHS who commission services on behalf of the individual person
- Third party arrangements- where the budget is passed to a third party (non-NHS) organisation to purchase services on behalf of the individual
- Direct Payments- where the budget is passed to the individual who may choose to purchase services from NHS, voluntary or private providers.

The CCG is looking to establish a partnership approach with social care, NHS providers and the voluntary sector that establishes the most cost effective implementation of the PHB expansion. The plan will enable the CCG to contribute to the national target of 50-100,000 PHBs in place by 2020/21 through an aspiration to achieve at least 225 PHBs across Brighton and Hove by end 2020/21.

5.3 Transforming Primary Care

Brighton and Hove CCG are acutely aware of the challenges facing general practice and along with national initiatives are striving at a local level to support our practices in maximising the resources available to them. NHS England's new General Practice: Forward View details the additional support for general practice, from investment in training and estates to addressing the red tape and workload issues. The CCG support practices at a local level in the development of community services and to work at scale through cluster working. The CCG is also supporting practices across the City to explore the potential and opportunity to form a more formal collaborative such as a legal federation.

The requirements of the Five Year Forward View will further support this national initiative through new models of working. In Brighton and Hove some general practices, for example, have developed a robust protocol which supports clerical staff in addressing additional administrative tasks to free

up GP's time; this can include reading, coding and taking appropriate action on clinical correspondence. Brighton and Hove practices have also undertaken a recruitment drive for proactive care programme and successfully recruited additional GP capacity and non-clinical support to promote proactive care. There is an on-going review and consideration of new ways of working such as the pooling of resources through the LCS and addressing needs at scale.

We will be working with NHS England during 2016-2017 to plan co-commissioning, which along with new models of working, will ensure the CCG can actively support a more sustainable primary care sector within the City.

Section 6- Quality and Patient Safety of the plan provides detail on how we will support the development of the workforce in general practice and in the development of staff in new services to support general practice.

Proactive Care

Establishing a more proactive approach to care and support remains an integral part of this wider agenda to provide integrated care across the system. We want to connect all parts of the system, whether they are proactive or urgent, so that people receive responsive care at the right time from the right service. The capacity and system leadership from proactive care will support these wider changes in the future.

Growing evidence suggests that achieving closer integration between health and social care is key to addressing the challenges of improving outcomes for patients and reducing pressure on services, particularly acute care. This integrated approach is especially important for people with long term conditions and older people whose needs are rarely just health or social care.

Proactive care is a model of care aimed at improving the identification and management of patients at risk of deterioration in independence. The model aims to provide pre-emptive support to avoid a hospital admission or care home placement. It is designed to improve the health outcomes for patients based on holistic and personalised care planning, proactive case management. This approach focuses on self-management, early intervention and health and wellbeing. It is anticipated that implementation of the service model will have a significant impact on our frail population, targeting support at the 1% of the population who are at highest risk of loss of independence due to complex needs.

Communities of Practice

The proactive service model will be grounded in primary care with a multidisciplinary team providing wrap around care for both patient and carer. Proactive care will be delivered by services that are arranged around clusters/communities of GP practices, centred on the needs of the registered population. General Practice will provide greater continuity of care, with more time to for patients who need it and will work in partnership with other parts of the health and care system to provide integrated care plans and service delivery.

Additional investment has been agreed to implement the proactive care model across Brighton and Hove in order to achieve the intended outcomes. It is anticipated that as the effect of proactive care is realised the investment can be offset through savings gained from a reduction in acute care activity and fewer conveyances and ambulance activity.

Alongside the developments in proactive care being coordinated and delivered by General Practice, work is being undertaken to improve the support and management of people with lower risk levels through a more preventative approach. This will be facilitated by the development of an outcome based Locally Commissioned Service (LCS), commissioned jointly with Brighton and Hove City Council.

This approach is based on combining all existing LCS's with all practices making the services available to their patients. It will provide an opportunity for practices working in clusters to design and deliver additional services to meet their specific patient needs. The delivery of this Locally Commissioned Service provides a significant opportunity to transform the delivery of primary care in Brighton and Hove, ensuring patients receive safe and effective care, reducing inequalities and improving the health and wellbeing of the population, with general practices working together to deliver better coordinated care.

General Practices, working in clusters, are currently developing cluster action plans. These will form the foundation of business cases for the detailed phasing of implementation and benefits during

16/17. There will be dependencies between these business cases and the Proactive Care Business Case to ensure a preventative approach is implemented across our population with a resulting reduction in the escalation of people to higher levels of the stratification model.

Workforce

General Practice is facing significant workforce issues across the country, and Brighton and Hove is no different. Our current Primary Care Strategy recognises the need for a primary care workforce that is skilled and able to deliver best practice to all age groups. We know that delivering the ambitions behind the new LCS outcomes framework will require a focus on developing our clinical and non-clinical workforce. The CCG is working with practices across the city to quantify the work force implications. We will continue to support primary care to access high quality training and education that is matched to the health needs of our population as well as supports a sustainable workforce. Along with the outputs of our recent Sustainable General Practice Conference this will inform a refreshed strategy for 16/17 onwards. See page 22 for more information on workforce development.

Homeless

In Brighton and Hove, homeless support services estimate that over 80 people are rough sleeping in the city currently (November 2015). In addition to this there are approximately 400 single homeless people in emergency and temporary accommodation while the city has 272 hostel places for single homeless people, with a current waiting list of 125 people.

The complexity of homelessness often requires a system wide response including the resources of: health, public health, social care, housing and community safety. Current services in Brighton and Hove are not well integrated, and are frequently commissioned by setting. This configuration does not reflect the service users experience or maximise the opportunity for people to recover from homelessness and move on to independence. To meet the increasing demands of homelessness and to provide more effective and efficient service responses, the CCG has developed a model based on a proactive approach to prevent homelessness and increase opportunities to support recovery and the journey to independence. The model has been developed with a wide stakeholder network.

This future model of care has at its centre a primary care led hub with a multidisciplinary outreach team working across the city in a number of spokes or settings. Health and care services are integrated within the Hub model and are proactive in their delivery to change the way care is accessed, increasing utilisation of primary and community services and reducing reliance on unscheduled and emergency care.

During 2014-2016 the CCG have tested the effectiveness and efficiency of this model with a number of pilots. Procurement for the model will commence in April 2016 with a phased implementation during 2016-17 with the intention of having the whole fully integrated model established by 2017.

Once fully established this model will deliver a number of benefits for the individual. These will include improved health through better access to the most appropriate services and preventative pathways as well as an increase in registrations with GPs and Dentists. It also covers effective and preventative health and social care and support in moving out of homelessness. The local healthcare system will benefit in terms of reduced reliance on unplanned and emergency care and a reduction in length of stay and excess bed days.

5.4 Responsive Community Services

To support the continued development of the CCG Clinical Strategy and our vision for transformation of care via the activated, supported patient and communities of practice, Brighton and Hove CCG has initiated a number of community based services and support mechanisms which work together to support independence and keep people out of hospital. To achieve this, our services need to be configured to facilitate quick responses for people when they have an urgent need for support. The CCG will deliver this by offering integrated community alternatives to hospital admission 24/7. Over recent years we have mitigated any increase in the number of A&E attendances and non-elective admissions by developing and strengthening community services.

In 2016/17 we want to move towards a whole system approach to integrated care with a focus on

prevention, self-management and coordinated support for our frail population. This will require the development of plans for clinical and service integration and the development of our commissioning and contracting approach in line with new models of care. We will use 2016/17 to work with our partners to redesign and organise community services around clusters of GP practices, with increased specialist support in the community.

New Model of Care for Community Beds

The preferred service model for patients is to receive rehabilitation and reablement within their normal place of residence but the CCG recognise that for a few patients this is not always possible/ desirable and some bedded facilities will be required.

The CCG is procuring is a more responsive and appropriate model of care for step-up/ step-down and rehabilitative care beds that is consistent across the Local Health Economy. The current model has experienced delays to admission and higher length of stays and it is expected that the new model will increase the flexibility and flow through the system.

To deliver this model the CCG is bringing together a range of partners under a single contract with a lead provider accountable for all aspects of the service delivery. This model will expand the availability of step-up care for primary and social care services and prevent avoidable admissions to acute care. Flow through the community bed service will further be optimized by cross system decision making, a clear focus on reablement, (aligning expected discharge dates to treatment goals) and access and discharge processes standardized. The acceptance of new referrals and patient discharge protocols will operate seven days a week.

This model will support optimised throughput and timely onward referral and discharge, thereby reducing lengths of stay across all bedded units. This new model of care will be in place in April 2017.

Discharge to Assess

This approach to discharge recognises that it is more appropriate to assess the future care and support needs of people who are medically ready to leave hospital within their own home, where they are familiar with the environment and are likely to feel more confident to engage in their own recovery and rehabilitation planning.

This model has been in operation since early 2015 with a dedicated team of qualified therapists and healthcare assistants. The CCG plans to extend this programme to enable 15 discharges per week initially, increasing to 30 plus per week during 2016/17.

The service will be integrated with our Community Rapid Response Service to ensure a consistent rapid response for both admission avoidance and supported discharge. This will include support provided by SCT Intermediate Care Services and Independence at Home.

Integrated Community Neurological Hub

The CCG seeks to improve the quality of life and health outcomes for people with long term neurological conditions in the city by establishing an integrated community specialist neurological hub. Current services are configured in condition - specific silos which are in contrast to ever increasing patient profile of comorbidities demanding holistic service solutions. The hub, although primarily containing neurological community services, would form the basis of a specialist hub in the community as part of the wider integration agenda. Expected outcomes include improved patient access and quality of intervention through improved service resilience and support through shared resources and capacity.

Integrated Social Care and Health Care Home Programme

The CCG continues to develop support for improved outcomes for people living in care homes by establishing an integrated Social Care and Health Care Home Programme. This work will bring together existing projects and work; spanning commissioning, contracts and quality across NHS and city council organisational boundaries and bringing them into a single programme to jointly tackle challenges, share resources, learning and relationships to make a greater impact on the sector.

Diabetes

The CCG awarded Sussex Community Trust a contract to deliver a 'one-stop shop' approach for Community Diabetes Service in 2015/16 with the aim of providing personalised support for patients in their local community. This integrated, consultant-led service will launch in 2016/17 and provide psychological, podiatry and dietetics support services to people living with diabetes. This service works in partnership with primary care to support patients to self-manage their condition with personalised care plans and improved access to high quality education and information.

The service will bring hospital and community teams closer together, working under a single leadership structure in collaboration with GP practices and Diabetes UK. It will support local GPs, nurses and healthcare assistants to increase skills and knowledge around the management of Diabetes in primary care. The Memorandum of Understanding has now been signed between BHCCG, Public Health and South East Clinical Networks (SECN) for the National Diabetes Prevention Programme. The prospectus (specification) has been submitted by SECN and The National Procurement Programme has appointed 4 providers from 9 bids. The Local evaluation of provider submissions (mini competition) will take place in early June 2016 with contracts awarded in late June. The providers have requested a 6-12 week mobilisation period and the NDPP will start working with people from the beginning of September.

The Local Authority Public Health service has also commissioned services which support diabetes prevention. These mainly focus on preventing type-2 diabetes through healthy weight and lifestyle and include: Active for Life physical activity interventions, health walks and Shape Up, and Weight Management Courses provided by the Food Partnership.

Joint Dementia Plan

Brighton and Hove's Joint Dementia Plan 2014/17 sets out the strategic vision for improving care and support to people with dementia as well as their carers. This plan is focused on improving and maintaining an integrated pathway for dementia from diagnosis through all stages of disease progression. During 2016-17 the focus will be on improving the quality of in inpatient dementia services and drive forward integration with other services in the community and voluntary sector. The CCG will support the implementation of community post diagnostic support, early interventions and action alliance services and will introduce and embed the Admiral Nurses service. The Dementia Action Alliance and a range of services will meet the second part of the Prime Minister's Dementia Challenge and provide support for people who have just been diagnosed with a dementia and their carers. The CCG will continue to work with primary care, and through reprocurement we will strengthen our Memory Assessment Model to ensure we sustain and meet the national targets for dementia diagnosis.

End of Life Care Plans

The requirement to have a system capable of sharing end of life care plans (sometimes referred to as an Electronic Palliative Care Coordination Systems (EPaCCS) is a key factor to improving quality of care for palliative patients and is a requirement of DH End of Life Care Strategy 2008. The way we manage and share information about people who are in contact with health and social care services plays a pivotal role in achieving higher quality care and improving outcomes for patients and service users. Electronic palliative care information sharing will be fully implemented in 2016-17. This is a whole system project, with providers from across the palliative care pathway involved. This includes; BSUH, SECAmb, SCT, Martlet's and all 44 GP practices in the city.

Greater analysis of equality of access to palliative and end of life care will be the focus of 2016/17, working to identify and spot health inequalities and develop mitigating strategies.

5.5 Safe and Effective Hospital care

Urgent Care Services

We will promote personal responsibility and self-care by providing readily accessible and reliable advice to help people make informed choices and access self-treatment options. This will include work promoting the role of the community pharmacy and continuing our innovative public information campaigns on how and when to access urgent care services and what alternatives are available.

During 2016/17 the CCG will recommission NHS 111 as a service that integrates with GP out of

hours, 999 and the local urgent care. We will streamline the entry points to emergency and urgent care by delivering a primary care led Urgent Care Centre which integrates a walk-in centre, minor illness and minor injury service and out-of–hours GP services.

We will ensure responsive crisis services by developing the role of 999 ambulances as mobile urgent treatment services and avoiding unnecessary journeys to hospital by using Community Paramedics. These will be aligned to communities of practice and work flexibly to undertake urgent home visits and respond to Red 1 and 2 calls.

Alongside the system changes led by the CCG, the CCG expects BSUH to undertake a programme of work to transform their Emergency Department in line with national recommendations and in response to "Transforming urgent and emergency care services in England – safer, faster, better: good practice in delivering urgent and emergency care". Specifically this includes:

- Remodelling the Level 5 accident and emergency area at the Royal Sussex County Hospital to make best use of the physical space;
- Focusing on early senior decision making and effective streaming of patients;
- Ensuring early clinical assessment of patients and clear clinical pathways for prompt transfer to specialist teams;
- Fast track and direct access for patients with clearly identified conditions;
- Calibrating staffing levels in the emergency department to match known variation in demand;
- Effectively managing ambulance handovers safely, via shared operating procedures thereby minimising delay and the need for cohorting;
- Further expansion of the ambulatory emergency care model;
- Expanding access for GPs and community teams to acute medical/surgical advice as an alternative to ED attendance;
- Fully supported Acute Medical Unit with consultant led twice daily reviews, therapy input and effective discharge arrangements;
- Improving flow through the hospital with effective and early discharge planning, criteria lead expected discharge date, daily reviews etc;
- Improving the discharge profile so that the majority of patients are discharged in the morning and consistently throughout the entire week.

Detailed information on these initiatives is contained in the Urgent Care Strategy and associated system wide plan.

Planned Care Services

We will continue to optimise the impact of our Referral Management System (RMS) by offering patients a choice of provider informed by average waiting time information at specialty level, prioritising clinical triage in key specialties.

The CCG, working with the local acute Trust and neighbouring CCGs, via the Planned Care Programme Board, has developed a detailed plan to maximise efficiency in pathways and free up capacity. This work is initially focusing on where BSUH is struggling to achieve Referral to Treatment compliance and includes Digestives Diseases and Neurology. So far the improvement plan includes the following workstreams:

- Reviewing existing primary care referral guidelines, low priority procedures, commissioning policies and existing community pathways to ensure they are fit for purpose, and being used to maximum effect and where possible, harmonised across the patch;
- An audit of two week wait referrals to understand recent increases in demand and ensure adherence to current referral criteria;
- Repatriation of activity that more appropriately sits with existing services but is currently undertaken within BSUH e.g. micro suction activity that should be delivered by the Community ENT service.

The CCG are also developing plans to expand even further the scope of our community services to enable a shift of activity from the local Trust. These plans include:

- The expansion of the community ENT and urology services
- The implementation of a community Irritable Bowel Service
- The expansion of our current ophthalmology service to include lens capsulotomy

Additionally the CCG is working with the Trust to implement more efficient and streamlined pathways in challenged specialties such as direct to test pathways in Digestive Diseases and one-stop pathways for hysteroscopy. We will continue to work with other providers in the NHS and independent sector to grow the market and offer a greater range of choice to patients. In particular, we intend to work with our neighbouring CCGs to commission, at scale, alternative provision for non-complex Digestive Diseases surgery pathways on a longer term basis.

5.6 Transforming Cancer Care

In response to both the national challenge and local need a "Five Year Forward Future Vision for Strategic Transformational Cancer Programme" has been developed in collaboration with the City Council. This Strategy provides a transformational framework for the diagnosis, treatment and care for people affected by cancer in the city. The approach addresses all components needed to deliver a gold standard service.

A number of specific projects are being developed and implemented to support the strategy ambitions. These are detailed below and collectively evidence our commitment to improving and transforming the experience of those whose lives are touched by cancer.

Raising Awareness and Earlier Diagnosis of Cancer

Evidence has shown that certain population groups within the city are more likely to experience specific types of cancer, experience delays in diagnosis and have a decreased survival time. Key to improving cancer outcomes and improving one year cancer survival rates overall is the early diagnosis and treatment of all types of cancer.

To address this crucial survival factor the CCG is working with the City Council and Public Health on a city wide Health Promotion Strategy. This strategy focuses on raising awareness of symptoms and improves access to diagnosis pathways for specific cancers, such as bowel, lung and breast. To further address those groups who experience inequitable diagnosis and outcomes these campaigns will also target specific population profiles through outreach work, communications campaigns and social marketing.

Improve Cancer Waiting Times to National Standards

The CCG are expected to support our patients and providers to deliver three key cancer access and treatment targets. These are 31 and 62 day waiting time target and the implementation of National Institute of Clinical Excellence (NICE) guidance for suspect cancer referrals. To achieve these standards, the CCG has increased endoscopy capacity for diagnosis of cancers. We are working with the Trust on the development of a diagnostic hub which will support direct test pathways for lung/chest X-rays and test colonoscopy. In addition to these, the CCG are commissioning a remote clinic for indolent haematological malignancies and implementing a suspect lung cancer pathway. The above measures will support waiting time and referral targets by increasing capacity, more efficient diagnostic access and clearer guidance when cancer is suspected.

Enhanced Survival

Raising awareness and increasing and supporting access to diagnostics tests and treatment is fundamental to increased cancer survival rates and to addressing premature mortality from cancer. Enhanced survival and improved life experience of those who have been treated for cancer is also crucial for patients. This approach provides support for those experiencing cancer to aid recovery and improve their experience of living with the condition. To this end the CCG has developed and initiated a Cancer Recovery Package to improve the health and outcomes during and post treatment. The programme covers a wide range of initiatives which in total deliver a comprehensive package of care, services and actions to improve the experience and outcomes of cancer patients.

5.7 Improving Mental Health

At a local level, mental health and wellbeing is identified as a clinical priority in the CCG Clinical Strategy. This also aligns with the ambitions across the city organizations to prioritise mental health prevention and treatment and improve the experience of those affected by mental health issues. This ambition is underpinned by our commitment to delivering parity of esteem for mental health services/treatment ensuring that those affected by mental health receive treatment and care of the same standard as physical health conditions. To support this commitment the CCG

and the City Council launched the Happiness Strategy in 2014.

The Happiness Strategy forms the bedrock of a holistic approach to mental health and wellbeing in Brighton and Hove. It includes developments for mental health services and provides a framework to embed mental health in all aspects of life, businesses and services across all ages. To achieve this, The Happiness Strategy covers a broader set of actions relating to employment, employers, training, and working with schools among others. Further to this, and in line with our concept of communities of practitioners, the CCG is committed to working with a wide range of providers across the City, including the community and voluntary sector, to provide services across a range of needs in a range of settings.

The CCG has specific mental health service developments planned for 2016-2017. These will support and facilitate our ambitions to create happier city, improve care pathways and deliver improved care and support for our population. During 2016-17, the CCG will:

- reduce the numbers of people detained under section 136, and continue to reduce the numbers of people being detained to custody;
- work with Brighton and Hove City Council to ensure that we review services offered to those individuals who have a diagnosis of autism or another autistic spectrum disorder. This will include scoping the need for additional diagnostic and support services for children, young people and adults;
- continue to develop our Transforming Care Partnership plan across Sussex to support the provision of out of hospital care for patients with complex learning disabilities and/or autism and mental health needs;
- invest in the mental health rehabilitation pathway across the city to better meet the changing needs of our population;
- re-procure Primary Care Mental Health Services as the current contract ends March 2017. The reprocurement provides the opportunity to extend the scope of the service to children and young people as well as ensuring that those people who neither meet the criteria for secondary or primary mental health services receive the support they need within a community setting.

Children and Young People's Mental Health and Well Being Transformation Plan

Brighton and Hove CCG has led the development of the Brighton and Hove Children's Mental Health and Wellbeing Transformation Plan which describes the vision of the City for services and support up to 2020. The Plan has been developed in response to findings from the Joint Strategic Needs Assessment and engagement activities with children, young people, their parents and carers as well as a range of providers, community and voluntary sector organisations and the NHS and Local Authority organisations.

The Local Transformation Plan outlines our plans around Children and Young Peoples IAPT and Brighton and Hove in the process of applying to become a member of the London and South East Learning Collaborative. During 2016-2017 the CCG will undertake a whole system scoping exercise to determine the current outcome measures and tools, evidence base and workforce and skills required to deliver CYP IAPT. The CCG will use this to identify and learn from best practice and other CCGs. This will form the base from which we develop an action plan to take forward CYP IAPT from 2017/18 onwards.

During 2016-2017 the CCG will progress and deliver the work streams which are briefly summarised in the sections below.

Innovative Communications and Support - The CCG will commission easily accessible, consistent, youth friendly, electronic and social media portals to promote mental health and wellbeing and facilitate access to the right help at the right time. This will include an anti-stigma campaign and is intended to reach all ages.

Primary Mental Health and Wellbeing- The CCG will extend the primary mental health and wellbeing in reach to all school clusters and through community and primary care services.

Sustain and Develop the E Motion Online Counseling Service -The CCG is investing in the development of this free online counselling service for young people aged 13-25 years who live in Brighton and Hove to deliver "live" counselling and increase its use by BME, young men and LBGT groups.

Complex Trauma Pathway - The CCG has commissioned a complex trauma pathway that will provide support to people aged 14 and over who have experienced trauma by offering a range of therapeutic interventions.

Investing in Vulnerable Groups - During 2016-2017 the CCG's working group will develop a mental health resource to support vulnerable groups such as children in care and adopted and fostered children.

Crisis and Out of Hours Care - The transformation plan for 2016-2017 includes the establishment of a working group to review and scope service and service developments for children and young people in crisis or needing out of hours mental health care

Youth Counseling Outreach - The CCG intends to continue to support an outreach counselling model to youth environments/clubs where young people spend time.

Teenage to Adult Personal Advisor Team - This team works with Brighton and Hove young people, aged between 14 – 25, who have an emotional, psychological or mental health need and where a specialist mental health service is required. During 2016-2017 the CCG will invest in this service to ensure it has the capacity to meet the needs of young people in transition from children's to adult's services.

Community Eating Disorder Service for Children and Young People (CEDS-CYP) - To address the new access target for Eating Disorders, Sussex CCGs (East and West Sussex and Brighton and Hove) will develop a Sussex-wide all ages pathway. The service will provide a comprehensive assessment and evidence-based treatment pathway for those with an eating disorder. The service will provide support to children, young people and their families as well as advice and guidance and awareness training for the whole system. This new provision will support a smooth transition to adult eating disorder services where required.

5.8 A Good Start

Children and Young People

The path to lifelong good health and wellbeing begins with ensuring our children have a good start. A foundation of the CCG Clinical Strategy is the engagement of the individual in embracing healthy behaviours and lifestyle choices. This culture starts with the children and families and the services which support them to make these choices. Children can also feedback into family/support units certain measures and actions which impact on health outcomes. Having happy, healthy children in our city will lead to happy, healthy adults and contribute to reduced reliance on the health and social care system.

The majority of health care for children and young people is provided by GPs in primary care and is in the context of looking after the family unit. The CCG aims to ensure that primary care services in the city have the capacity and capability to offer high quality health care to children and young people. We will do this through the Locally Commissioned Service (LCS) outcomes contract, building on the work done throughout 2015-16. The future vision is to develop children's health hubs around GP clusters providing for more integrated and multi-disciplinary approaches. In particular to look at more joined up care and sharing of skills across secondary and primary care.

The CCG are committed to bringing care for children and young people, particularly those with the most complex needs, closer to home and away from hospital based settings. This is reflected in the work we will do to review and re-design children's community nursing; the development of pathways to provide closer integration of mental and physical health care and work to develop streamlined pathways for early help in social care. We will be working closely with our key partners, BSUH, SCT and the Local Authority, to achieve this.

The work we are doing to re-design our children's community nursing services will support the timelier discharge of children and young people from acute care, and support them and their families to recover more quickly form episodes of illness or to manage longer term conditions more effectively at home.

A Joint Children and Young People's Health and Wellbeing Strategy has been developed with Brighton and Hove City Council and will support the delivery of more integrated, proactive and preventive services. Further to the CCG considers how the change can include all ages in service developments and improvements to services. A recent example is the Sussex wide Eating Disorder service and Autism pathway.

Maternity

Maternity Services in Brighton and Hove are provided by Brighton and Sussex University Hospitals Trust. There is an obstetric led unit at the Royal Sussex County Hospital site and women can also choose to have a home birth which account for about 6% of local births. Brighton does not currently provide full choice of birth place as it does not have a midwifery-led unit (Birth Centre). A wider independent review of NHS maternity services, published in February 2016, was undertaken to assess how best to respond to England's growing birth rate and the need for well-staffed and safe services that give mums more say over their care.

The CCG commissioners have reviewed the recommendations from the national maternity review, published in February 2016, and these will be taken into account in the development of our maternity commissioning plans. The key recommendations are:

- **Personalised care** – centred on the woman, her baby and her family. This includes having a genuine choice over where and how she gives birth; development of personalised care plans setting out decisions about her care; the use of personal maternity budgets.
- **Continuity of care** – women having access to the same team of midwifes throughout pregnancy, birth and the postnatal period.
- **Safer care** – developing a culture of learning and continuous improvement; good quality data and robust referral pathways ensuring access to the right care, particularly specialist care, when needed.
- **Better postnatal and perinatal mental health care** – to address historical underfunding in this area and reduce the number of postnatal maternal deaths associated with mental health needs.
- **Multi-professional working** – including multi-professional learning as part of pre-registration training and continuous professional development for midwives.
- **Working across boundaries** – this includes working across geographical and organisational boundaries; development of community hubs and agreed standards and protocols across a local maternity system. The Sustainability and Transformation Plan will help to support planning and delivery across a wider geographical area and to further develop partnerships across the local maternity system.
- **A payment system** – that fairly and adequately compensates providers for delivering high quality care to all women.

Brighton & Hove CCG has already begun to make progress against some of the key Maternity Review recommendations. We are working with our local provider on developing small teams of midwives to deliver continuity of care and the development of community hubs. The City has had a Perinatal Mental Health Team for 3 years. We have invested in this service during 15/16 to ensure it has the capacity and skills to meet the needs of pregnant women and new mothers who have mental health needs. We will continue to focus on this area in line with national requirements.

A safe, reliable and high quality maternity service should be consistently provided twenty-four hours a day. The CCG has a number of assurance measures in place which provide information on the safety and quality of the maternity services provided. These include a monthly dashboard with a range of key indicators of performance and safety; some benchmarks have been agreed and set nationally by the Royal Colleges and other professional bodies so that we can ensure our local services are following best and safe practice. Such indicators cover the hours of consultant presence on wards in relation to the number of births and the ratio of midwives and one-to-one care when women are in established labour. These indicators are reviewed and monitored in conjunction with a range of clinical outcomes. Together, with patient experience surveys, this information provides triangulated intelligence about the quality and safety of our local maternity service.

In addition to this monitoring the CCG and the maternity service work with work with our parent – led Maternity Services Liaison Committee and are responsive to the range of high profile national and regional initiatives to drive improvements in quality and patient safety. The recommendations from the Morecombe Bay enquiry, for example, have provided additional benchmarks to ensure robust governance arrangements in maternity units.

Further to the measures taken above there is also a significant national initiative to reduce the numbers of stillbirths and early neonatal deaths with the introduction of a "care bundle". Extensive evidence gathering and clinical engagement has

identified four elements which if implemented as a package of care to all pregnant women, has huge potential to significantly reduce stillbirth rates. These elements are:

- Smoking cessation
- Identification of fetal growth restriction
- Raising awareness of reduced fetal movements
- Effective fetal monitoring in labour

We will be working closely with BSUH to support the delivery of the Secretary of State's challenge to reduce infant mortality and to ensure that Brighton and Hove is a safe place to give birth.

5.9 Medicines Management

Medicines are the most common intervention and biggest cost, after staff, in healthcare. Getting the most from medicines for both patients and the NHS is becoming increasingly important as more people are taking more medicines. There are a number of concerns about England's use of medicines:

- 30-50%* of medicines are not taken as intended and patients have insufficient information to support taking medicines;
- 5-8%* of hospital admissions are due to preventable adverse reactions to Medicines;
- Medication errors have risen as a proportion of all errors reported from 8.19% to 11.02% from 2005 to 2010;
- Medication wastage in England per year is approximately £300 million of which 50% is estimated to be preventable;
- There is a real threat to healthcare from antibiotic resistance.

*Range comes from different studies in the literature

Our medicines optimisation strategy is central to the work of the CCG due to the key role medicines have in our health system. It sets out six key approaches to medicine optimisation for Brighton and Hove and these are outlined in the paragraphs below and full details are contained within our CCG Medicines Management Strategy.

The CCG will maximise care gains across health and social care by innovative management of medicines at the best obtainable value. We will continue to monitor prescribing spend against budgets set for GP practices and other providers. We will use our prescribing monitoring dashboards to identify outliers with prescribing and work with partners to address any problems or learning needs

The CCG will support workforce development activity to create a sustainable healthcare system with particular emphasis on the pharmacy workforce and medication review. To realise the potential efficiencies from the prescribing budget we will need to increase the capacity and skills in Primary Care to change how we use medicines at practice and cluster level. Our work will need to include engagement of the partner organisations in joint policy across the whole health economy with leadership for implementation provided by the specialists for each therapeutic area.

The CCG will continue to deliver Medicines Optimisation which aims to engage with patients to better understand their issues around medicines and to co-develop solutions that support them with their medicines taking. There will be specific focus around medicines use in care homes and in the over 75s because of the known adverse impact of high medicine usage in the frail elderly population (polypharmacy).

We will look at the following specific areas/projects as part of our workplan:

- Polyprescribing and Deprescribing,
- Stoma,
- Continence,
- Antimicrobial Stewardship (AMS),
- Atrial Fibrillation,
- Hypertension,
- Diabetes,
- Neuropathic Pain,
- Nutrition,
- Respiratory,
- Medicines Safety and Risk Reduction,
- Medicines Waste.

We have set KPIs for all our projects and will be monitoring performance against KPIs on a regular basis.

5.10 Information Management and Technology

The CCG recognises that the opportunities provided by technological developments, and their facilitation in information sharing and management, are core to the future design and innovation in service improvement. New technologies offer

significant opportunities to improve patient experience, productivity and quality across health and social care services. The CCG will begin the implementation of the CCGs Digital Roadmap during 2016-17.

During 2016-2017, the CCG are preparing the foundations to ensure effective development and delivery of the national 2020 vision. To do this, the CCG has taken steps to ground the prerequisites for successful delivery in our operational thinking. These enablers include a CCG informatics vision and strategy embedded within our commissioning pathway; the two are intrinsically linked and to deliver this ambition effectively the CCG recognise the need for resources of expertise, seniority, and time. Assurance of these innovations will need effective governance and coordination mechanisms, particularly across organisations.

This organisational bedrock will support the streamlined care delivery which makes effective use of information and technology wherever there is a benefit. This will include a view only portal for professionals across organisations to access patient records held in multiple organisations. It is envisaged that these professionals will share working space to record and work together on a subset of care plans for patients with complex needs or a high level of risk. This will be facilitated by an effective management / intervention planning toolset. Patient care will be improved through the effective use of specialist clinical expertise through teleworking initiatives. For patients there will be a patient portal to view records, enter and access information.

These ambitions will be evidenced and measured by the following key performance and quality indicators:

- All discharge summaries to be send electronically;
- Full implementation of the 2015/16 priority digital standards;
- Implementation plan for pipeline digital standards 2016-2020;
- Improved use of available shared records such as SCR;
- Full engagement with development of the Digital Footprint and dedicated resource to support delivery.

6. Quality and Patient Safety

The CCG monitors patient safety measures and holds commissioned service providers to account through a range of measures. These include monthly Quality Review meetings, which consider mortality rates – including governance systems in place to review, and investigate where required, unexpected deaths. Where deaths or serious harm occur as a result of service failures, the CCG ensures providers report these as Serious Incidents (in line with NHS England Framework 2015).

The CCG continues to host a pan-Sussex fortnightly serious incident scrutiny panel – the panel reviews all investigation reports and identify any themes across the county. When common themes are identified specific support and training is provided for organisations to address the issues and support improvement. For the past two years Brighton and Hove CCG has hosted the annual Patient Safety Conference and have established a pan Sussex learning model developed from the identifications/analysis of national and local issues and incidents.

Locally, the CCG Quality team undertakes a timetable of quality assurance visits, both planned and unannounced. These may be actioned following any themes/issues identified from serious incidents or from triangulation with other sources of quality-related information.

In line with national targets, relating to zero hospital acquired MRSAs and reducing numbers of C.Difficile infections and healthcare associated infections, the quality team focus on both hospital and community services with specialist input from the CCG Infection Prevention Nurse. The CCG also monitor outcomes of agreed CQUINs linked to patient safety - including sepsis, acute kidney injury, mental health care in A&E and medications safety.

Although NHS England has the immunisation programmes and directly commissioning cancer screening programmes, there are direct linkages through to primary care in the support of patients and the promotion of these services. The CCG works closely with these bodies and local public health to improve immunisation uptake within the

City. This includes identification and provision of training for primary care.
Safeguarding of vulnerable members of our population, both adults and children, is a priority for the CCG. Services are monitored against agreed safeguarding standards and against the CCGs Safeguarding Assurance Framework, with provision of specialist advice and support from CCG Designated and Named Safeguarding leads.

The CCG continues to monitor patient experience measures and hold commissioned service providers to account via Quality Review meetings. These measures include:

- complaints – looking at numbers, types of complaints, trends in reporting, with assurance that providers make changes to services based on complaints they receive;
- friends and family test – response rates and, as for complaints, focussing on a qualitative feedback to FFT and seek assurance that providers make changes based on feedback;
- receiving feedback from providers' internal Patient Experience' and Patient Engagement meetings, and ensure providers have robust methods of receiving patient feedback;
- ensuring themes and trends from soft intelligence received by the CCG via the 'Feedback on Providers' mechanism is addressed with providers.

Patient experience data also supports quality monitoring and improvement in primary care through the engagement of the Friends and Family Test information. In addition patient experience issues are conveyed to the CCG Governing Body via the Lay member on the Governing Body. Our lay member chairs the Patient and Public Involvement leads meeting and provides direct input to Governing Body meetings.

Transforming Care Plan

Transforming Care is a program of work to improve the care for people with learning disabilities, autism and/or challenging behaviour. Brighton and Hove has made considerable progress in supporting people in in-patient care to move toward discharge in line. Brighton and Hove commissioners continue to work with local providers to plan and develop future services that meet the needs of people with learning disabilities who are currently in hospital, or who are at risk of admission.

In June 2015, the CCG agreed funding to enhance the integrated Community Learning Disability Team (CLDT). This will enable the team to deliver a model of crisis prevention and to reduce the frequency of specialist hospital admissions for people with learning disabilities. The CLDT, together with commissioners, have worked to ensure that pre-admissions CTRs are completed in a timely manner to ensure the appropriateness of admissions to hospital and develop a discharge plan is from the point of admission.

The CCG have also funded a community based reviewing post to ensure that lengths of stay for people in specialist hospital provision are minimised. This post also proactively supports those who have been in longer term to move to more community based provision where appropriate.

The development of county wide partnerships support the ambition of transformational change to the services which support individuals and their families with learning disabilities, autism and or mental health issues with or without challenging behaviour from birth to grave. Brighton and Hove CCG is a part of the Sussex "footprint" which includes the seven Sussex CCGs and East Sussex, West Sussex and Brighton and Hove Local Authorities. Please refer to the Transforming Care Plan for full details.

CCG Workforce Wellbeing

The CCG is signed up to the Public Health England Workplace Wellbeing Charter and is due to be assessed in May 2016 against its criteria. Through much of the work which has been done with HR, Organisational Development and the staff themselves, we believe we will have achieved a very good level of commitment to staff wellbeing. Our recent staff survey results show that our staff recognises the CCGs commitment to their wellbeing within the workplace. CCG staff are offered lunchtime yoga sessions, after work netball and the sports and social club organise a range of events such as attendance at Glyndebourne and monthly socials.

Workforce Development

The CCG provides an extensive training and development programme and support all staff training needs which are identified in annual appraisals and PDPs. Staff also partake in NHS Leadership academy courses

Further to the support and development of our own staff, the CCG will also focus on working with Primary Care and the CRN KSS primary care delivery manager to raise awareness of research involvement through the patient participation groups. We will also identify and work with providers to support the application of research findings in new models of service delivery. During 2015-2016 the CCG has been trialling a knowledge awareness librarian pilot to support MDT Cluster development and new ways of working. We will continue to support post in 16-17 and an evaluation is planned for 2016/17.

The CCG will up-skill the non-medical workforce in Primary Care with education and training. This will support the expansion of their roles and help to fill the gaps in the workforce, so effective patient-centred care can still be delivered within Primary Care. Reception staff will be offered training to improve communication skills, and help them to look at improving patient satisfaction. The CCG will also support work with receptionists who would like to become Healthcare Assistance (HCA), providing Phlebotomy training and competencies within HCA framework.

The CCG supports training for practice managers to help them with the transformation of primary care and adopt new ways of working, and take on more leadership roles within the Clusters.

The CCG will continue to work with providers to deliver City and Guilds QCF (NVQ) level 2 and 3 for Healthcare assistants so they can expand their role within the practice and support practice nurses. This will support practice nurse capacity for focus on patients who have more complex needs.

Training is also provided for new practice nurses so their transition into Primary Care is smoother and they can deliver safe and effective care and be autonomous sooner.

Practice nurses, supported through commissions from HEE-KSS, will have the opportunity to train as specialist practitioners so they can become leaders within the practice and in the Clusters, or work as advanced practitioners allowing GP's more time with patients with more complex needs. The CCG deliver various workshops so staff can keep up to date and deliver safe quality care. We are also involved in helping practice nurses to attend modules at University so they can expand their roles.

We encourage further general practice workforce development via mentorship training for practice nurses so they can then mentor Pre-Registration Student nurses in practice. The aim is to attract nurses into primary care by showing them what it is like to work in Primary Care. There are 22 planned placements of students for 2016 and the aim is to increase this number. Positive feedback from students wishing to now work in Primary Care when they qualify has already been received. It is hoped this will increase the workforce in the future.

The CCG is working with other stakeholders in Brighton and Hove to link up training of non - registered professionals. The aim is to increase awareness of home carers, care home and nursing home staff of when to seek further help and when to refer people so problems can be detected sooner, the aim being to prevent hospital admissions. This project is due to be completed in 2016/17.

Continuing Health Care

The NHS Continuing Healthcare National Framework provision can be delivered through a care home placement or a package of care in the clients own home. Support plans are individualised to meet the client's health care needs. Care is commissioned using clinical expertise and local social care networking; this empowers clients to take control of their own health needs. This is facilitated through health education and to provide the tools to enhance best health outcomes.

Recent changes to legislation provide some challenges to NHS Continuing Healthcare (CHC) Theses include the following:

- The National Living Wage 2016 – this new legislation will commence in April 2016 and will have a financial impact on the continuing healthcare budget. Providers are contacting the CCG seeking increases in their care fees;
- Under the Care Act 2014 the CCG now ensures that clients have access to an advocate or Independent Mental Capacity Advocate (IMCA) if they lack capacity and have no other means of advocacy;
- Constraints to the Local Authority budget mean that nursing homes are increasing their care fees to ensure that their

businesses remain financially viable. This could impact on local placements for clients and will impact on patient choice;
- The ageing population living longer with more complex health needs, keeping the older people population longer, increasing pressure on CHC budgets;
- Personal health budgets figures suggest that the numbers of PHB's are increasing and the costs may be more than traditional packages of care.

Brighton and Hove CCG will take action to mitigate the risks identified and to ensure all individuals who are entitled to continuing healthcare support have access to timely high quality services and support by:

- Working in partnership with individuals and their family and carers;
- Working collaboratively with partners to deliver consistent care both national and locally;
- The Continuing Healthcare Assurance Tool (CHAT) has been implemented to help improve standards, support, and improve assessments and care pathway delivery;
- Brighton and Hove CCG have continued to progress Closedown cases and are on target to complete this work stream by September 2016;
- There is an increasing need to respond to people at the end of their life with increasing requests for "Fast-track" assessments and rapid implementation of packages of care and support. The Funded Care Team are working to extend an existing model of block contracted hours for end of life care with local providers. This approach is to stabilise the delivery of appropriate care in a timely manner.

During the last quarter Adult Continuing Healthcare has funded 532 clients. Children's Continuing Healthcare is currently funding 13 children.

7. Governance and Assurance

Good Governance

The CCG has a clear and systematic governance and decision making process which is articulated in detail in our constitution. During 2015/16 the CCG made a number of changes to committees, policies and governance to further strengthen our governance and assurance processes.

This included reviewing and strengthening the governance arrangements for the Performance and Governance Committee. The CCG appointed a lay member as chair and formalising and refocusing the meeting on key performance issues. The Terms of Reference were amended to reflect this and another forum created to address operational issues with the CCG Senior management team forming the membership.

The role of the Clinical Strategy Group, a subcommittee of the Governing Body, has been reviewed and emphasis placed on its role in focusing on the long term strategic development of the CCG reemphasised alongside its role of clinical pathway development. The CCG Clinical Strategy has been driven by the aspirations and goals of the CSG to deliver the FYFV recommendations and improve care and services for our patients.

Further to these developments and in response to the Annual Assurance rating of not assured from NHS England, the CCG have commissioned a Capability and Capacity Review from an external consultancy with the specific remit to consider the leadership and committee structure of the CCG. This is due to report in early 2016.

Performance Management

The CCG has taken a range of steps to improve its management of the performance of both the system as a whole and our individual providers. These steps have been taken in response to the on-going challenges of our provider performance specifically in A&E, referral to treatment times and cancer 62 day waits.

Measure taken to enhance existing contract and performance management processes to include:

- Changes to the contract management meetings with increased focus on timely and accurate reporting of attainment and provider accountability for compliance against standards;
- Requesting credible remedial/recovery actions plans as standard and requesting evidence that these are having desired impact;

- In-depth performance reports under regular scrutiny at the Performance and Governance Committee;
- Joint CCG/BSUH PMO formed to review and challenge the unscheduled care plan which underpins the recovery trajectory;
- Issuing contractual penalties to providers for non-delivery of mandated targets;
- Monthly Single Performance Conversations and Quality Review meetings with BSUH;
- Regular Executive Level PMO meetings which include neighbouring CCGs and Unscheduled Care Operational Resilience Group meetings.

Completely new performance management processes include the introduction of formal multi-partner Director level reviews for the major change programmes – Performance Review Meetings. These forums will address issues by exception and will be underpinned by effective programme tracking by the PMO analysts. In addition the Unscheduled Care Operation Group PMO is informed by bi-monthly highlight reports which are completed by project leads across the local health economy organisations involved in the drive for improved performance in this area. These highlight reports are also presented to the System Resilience group on a regular basis.

Programme Management Office

The CCG has an established Programme Management Office (PMO) to oversee and ensure the effective, consistent and co-ordinated delivery of projects. The PMO is an organisation-wide function that has two important roles:

- It supports the planning, delivery and evaluation of programmes by providing advice, guidance, standard operating procedures and templates.
- It monitors the performance of programmes to ensure that work is on track, delivering within budget and achieving the expected benefits.

During 2015-2016 the PMO team has been strengthened with an increase in dedicated resources and a clearly defined remit. The Core PMO team now includes two business intelligence analysts, representations from finance officers and a dedicated PMO support officer. The focus of this team is the support of programme development and the assurance of plans.

Risk Management

Risk management is a fundamental part of quality and safety assurance and the CCG has an integrated Risk Management Framework covering clinical, financial and corporate risks.

The organisation has an established risk management system which identifies and tracks project and team level risks. These are reviewed monthly and are recorded and reported on dedicated Ulysses Safeguard Risk Management Software. The Corporate Risk Register and Report are reviewed and discussed monthly at the Performance and Governance Committee, prior to presentation to the Governing Body. Clinical Risks are also reviewed at the Quality Assurance Committee and there are clear mechanisms through which quality and patient safety risks are escalated and resolved. The CCG risk management and recording process is assured through review at the monthly Audit Committee and the Annual Internal Annual Audit. For 2015/2016 the Internal Audit Team reported they were reasonably assured by the CCG risk management process and reporting. The CCG Risk Manager has responded to and implemented recommendations from this audit.

The CCG Corporate Risk Register brings together the risks collected from team and project risk registers and maps them to the principal organisational risks identified by the Governing Body and partners across the city. These in turn are mapped to our strategic objectives. The Governing Body review and update the CCG Strategic Objectives and risks to these on an annual basis. This process is described in our Assurance Framework.

The Operating Plan Risk register is contained in Appendix 1.

8. Conclusion

The CCG Operating Plan 2016-2017 confirms the commitment the CCG has to meeting the challenges set by the NHS Five Year Forward View, the NHS Mandate and the transformational ambitions described in the CCG Clinical Strategy. While acknowledging the challenges the CCG has faced in terms of the performance of the local hospital trust the plan provides solutions to the attainment of a recovered and a sustainable future model of care which is set in the context of the

emerging themes of the Sustainability and Transformation Plan.

Although described in separate sections the totality of our 2016-2017 building block plans are co-dependent, driving service and workforce development towards a model of sustainable, high quality and truly, integrated partnership working. Key to the success of this delivery is the development and support of the engaged and empowered patient. By coming together, as organisations and individuals, and making fundamental shifts in our perception of models of service delivery and whole system engagement this approach aims to deliver a local health and care service that engenders equality, improvement, independence and engagement.

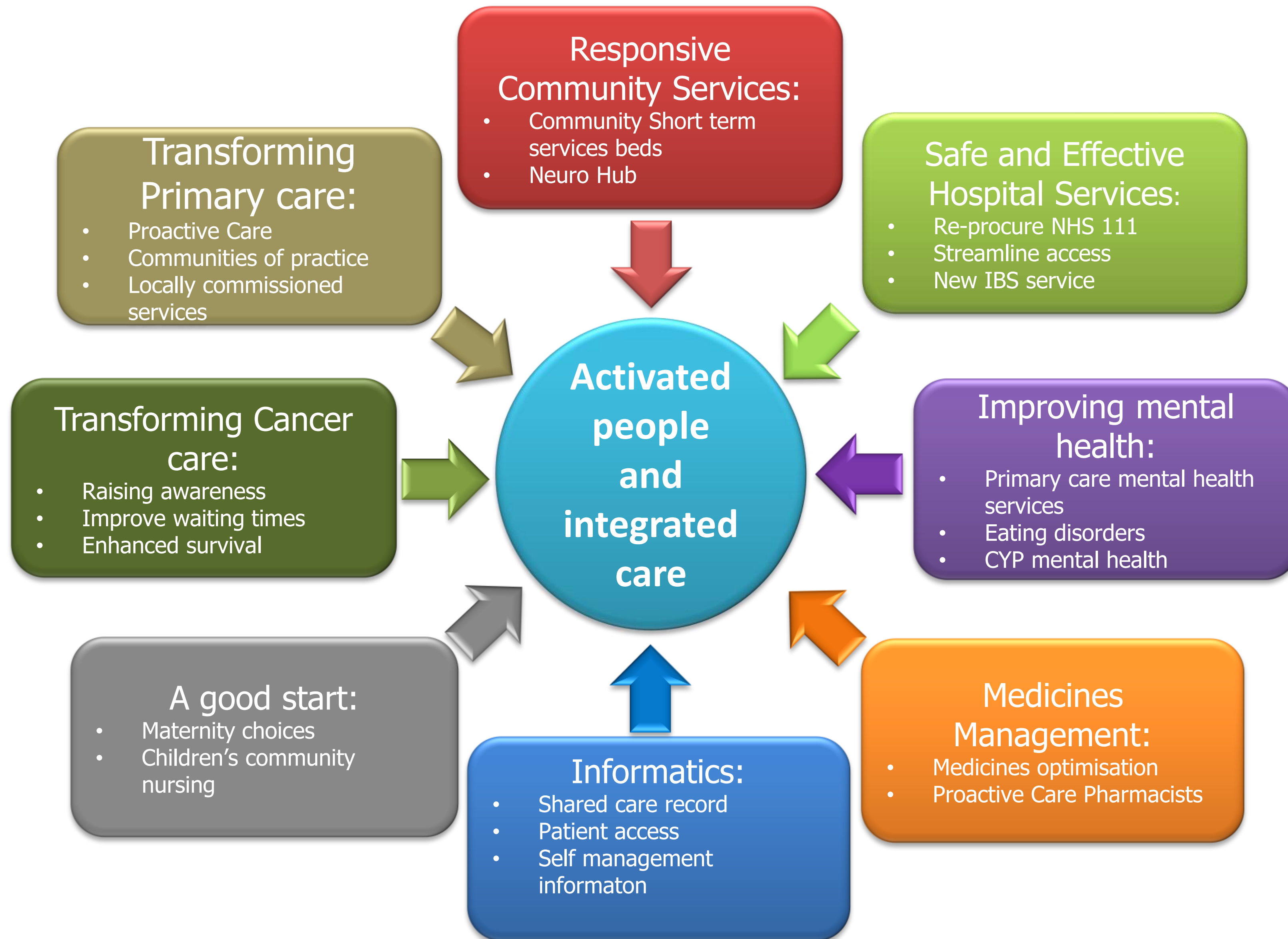
Appendix 1 – Risk Register

Primary Risk	Risk Score	Mitigation	Residual Rating
There is a risk that performance against targets may not be met in 2016/17, particularly in A&E access targets including 18 weeks, IAPT, RTT ,HCAI and cancer 62 day wait.	20	• System wide demand and capacity planning including detailed referral analysis to understand the level of demand for planned care services and the distribution of the demand. • Delivery of the integrated urgent care model • Increased primary and community services including delivery of proactive care, IBS and LUTS services	12
There is a risk that the CCG will not secure adequate activity to sustainably deliver standards for planned care	20	The CCG is actively seeking additional planned care activity from independent sector and NHS providers	16
There is a risk that Brighton and Hove increasing pressures on primary care organisations may impact on their ability to deliver a robust and sustainable primary care structure which will adequately support the delivery of GMS services for the people of Brighton and Hove	20	• Workforce and development programme specifically for general practice • Workforce and organisational development group for delivery of the MCP new ways of working being trialled by primary care in an effort to ensure that general practice is effective, well organised and, above all, sustainable in the future	16
There is an expectation that NHS and social care funding will be restricted over the next 5 years and there is a risk that the CCG will be unable to contain costs in the same time frame. This is because of the time lag in the development of transformational programmes designed to deliver efficiencies	16	Ongoing assessment of likely impact of plans. Operational and Strategic Plans reviewed and refreshed annually enabling the CCG to anticipate pressures and adjust accordingly	12
The CCG recognise that during the current period of local executive transition there is a risk that an interim loss of corporate knowledge may impact on the timely delivery of 2016/2017 ambitions	9	All executive team posts have been successfully recruited to, both the Chief Operating Officer and the Director of Finance are now in post	6
There is a risk that the recognised workforce shortages and workforce capacity issue, reported nationally and locally may have an impact on the CCG plans to deliver new and changed services	16	• up-skill the non-medical workforce in Primary Care with education and training • training for practice managers to help them with the transformation of primary care and adopt new ways of working, and take on more leadership roles within the Clusters.	12

Appendix 2 - Glossary of Abbreviations

AMU	Acute Medical Unit
BHCC	Brighton and Hove City Council
BME	Black and Minority Ethnicity
BSUH	Brighton and Sussex University Hospital Trust
CCG	Clinical Commissioning Group
CEDS-CYP	Community Eating Disorder Service for Children and Young People
CHC	Continuing Healthcare
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRN: KSS	Clincal Research Network: Kent, Surrey and Sussex
CVS	Community and Volunteer Sector
DFT	Direct Funds Transfer
DH	Department of Health
ED	Emergency Department
EDD	Estimated Discharge Date
ENT	Ear, Nose and Throat
EPaCCS	Electronic Palliative Care Coordination Systems
FFT	Friends and Family Test
FYFV	NHS Five Year Forward View
GMS	General Medical Services
GP	General Practitioner
HCA	Health Care Assistant
HEE-KSS	Health Education England-Kent, Surrey and Sussex
IAPT	Improved Access to Psychological Therapies
IBS	Irritable Bowel Syndrome
IPCT	Integrated Primary Care Team
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LCS	Locally Commissioned Service
LGBT	Lesbian, Gay, Bisexual and Transgender
LUTS	Lower Urinary Tract Service
MDT	Multi-disciplinary Team
MRSA	Methicillin-resistant *Staphylococcus Aureus*
MSK	Musculoskeletal
NHSE	National Health Service England
NICE	National Institute for Health and Clinical Excellence
PHB	Personal Health Budget
PMO	Programme Management Office
PPG	Patient Participation Group
QIPP	Quality, Innovation, Productivity and Prevention
RMS	Referral Management System
RTT	Referral to Treatment Time
SALT	Speech and Language Therapy Service
SCR	Shared Care Record
SCT	Sussex Community Trust
SECAmb	South East Coast Ambulance
SPFT	Sussex Partnership Foundation Trust
SRO	Senior Responsible Officer
TCP	Transforming Care Partnership

Appendix 3 – Summary of Plan



Appendix 4 – Gantt Chart

BH CCG AOP MILESTONE PLAN 2016-17

Overall RAG Rating - Scoring Key

- <1 month delay; 90% KPIs achieving target; risk scores <9
- 1-2 month delay; 50-89% KPIs achieving target; risk score >9
- 2+ months delay; <50% KPIs achieving target; risks 12+

REF	ACTION/TASK	RESPONSIBLE TEAM	2016/17 Q1	Q2	Q3	Q4
001 PLANNING, DELIVERY AND FINANCE						
1.1	Business Case to agree drawdown amount of excess surplus	Finance	■			
1.2	Contribute to the development of the Sussex-wide Sustainable Transformation Plan (STP)	Planning & Delivery	■			
1.3	Identify QIPP saving initiatives and review investment plans	All	■			
002 ACTIVATING PATIENTS						
2.1	CCG Self-management strategy developed	Commissioning - PC	■			
2.2	Full roll-out of single information portal for the public (MyLife)	Communications & Engagement	■			
2.3	Detailed plan with approach for PHB budget setting	Commissioning - PRIM. C		■		
2.4	Agree system-wide CQUINs with an umbrella theme of patient activation and care planning	Quality & Safety			■	
2.5	Extend roll-out of Personal Health Budgets (PHBs) to a wider client group	Commissioning - PRIM. C			■	■
003 TRANSFORMING PRIMARY CARE						
3.1	Review of cluster level Business Cases submitted to CCG	Commissioning - PRIM. C	■			
3.2	Continuation of Knowledge Awareness Librarian pilot to support MDT cluster development	Quality & Safety	■	■		
3.3	Evaluation of Knowledge Awareness Librarian pilot	Quality & Safety			■	■
3.4	Refreshed Primary Care strategy developed	Commissioning - PRIM. C				■

004 IMPROVING MENTAL HEALTH		
4.1	Implement new access and waiting standards in Early Intervention in Psychosis pathways	Commissioning - MH
4.2	Develop an all-age complex trauma pathway	Commissioning - CYP & MH
4.3	Develop a Sussex-wide Community Eating Disorder Service all-ages pathway	Commissioning - CYP & MH
4.4	Review of all contracts with the Community Voluntary Sector (CVS)	Commissioning - MH
4.5	Reprocurement of the Wellbeing Service, including IAPT services	Commissioning - MH
4.6	Re-procure Primary Care Mental Health Services	Commissioning - MH
4.7	Develop a Sussex-wide plan to transform care for people with learning disabilities	Commissioning - MH
4.8	Mobilisation of an all-age complex symptomology pathway	Commissioning - CYP & MH

005 INTEGRATING HEALTH AND SOCIAL CARE		
5.1	Phased implementation of a specialist integrated community neurology hub	Commissioning - Community
5.2	Procurement of the integrated homeless model	Commissioning - MH
5.3	City-wide services for befriending and navigation in place	Communications & Engagement
5.4	Phased implementation of the homeless model across the city	Commissioning - MH

006 CARE CLOSER TO HOME		
6.1	Integrated Primary Care Teams (IPCT) aligned with six GP clusters	Commissioning - Community
6.2	Discharge to Assess service integrated with Community Rapid Response Service (CRRS)	Commissioning - Community
6.3	Integrated consultant-led Community Diabetes Hub launch	Commissioning - Community
6.4	Mobilisation of a new model of care for community beds	Commissioning - Community

007 SAFE AND EFFECTIVE HOSPITAL CARE		
7.1	Develop a detailed plan to maximise efficiency in pathways and free up capacity	Commissioning - PC
7.2	Commission alternative provision for non-complex Digestive Diseases surgery pathways	Commissioning - PC
7.3	Full delivery of ECIST recommendations to transform RSCH Emergency Department	Commissioning - UC
7.4	Design primary care led Urgent Care Centre (UCC)	Commissioning - UC
7.5	Develop a diagnostic hub to support direct test pathways for lung/chest X-rays/test colonoscopy	Commissioning - PC
7.6	Begin implementation of the new UCC model	Commissioning - UC
7.7	Recommission NHS 111 to integrate with GP OHH, 999 and the local urgent care	Commissioning - UC

	system	
7.8	Undertake an audit of patient experiences at different stages in cancer pathways	Commissioning - PC
008 MATERNITY AND CHILDREN'S SERVICES		
8.1	Develop a service specification for maternity services	Commissioning - CYP
8.2	Establish baseline against national maternity services review	Commissioning - CYP
8.3	Develop a performance reporting dashboard for paediatric hospital	Commissioning - CYP
8.4	Introduction of a care bundle to tackle still birth by improving four elements of care	Commissioning - CYP
8.5	Develop a performance reporting dashboard for community based services	Commissioning - CYP
8.6	Recruitment and mobilisation of children's community nursing	Commissioning - CYP
8.7	Brighton & Sussex Universities Hospital Trust (BSUH) to develop a co-located Birth Centre	Commissioning - CYP
009 MEDICINES MANAGEMENT		
9.1	Recruit a Stoma Nurse to improve stoma care prescribing in primary care	
9.2	Recruit Prescribing Support Dietitian to work with primary care on oral nutritional supplements	
9.3	Pharmacist in post for each cluster to support Proactive Care	
0010 TECHNOLOGY TO EMPOWER PATIENTS		
10	Publish CCG Local Digital Roadmap	Planning & Delivery
10	Begin implementation of Digital Roadmap	Planning & Delivery
10	View only portal in place for professionals across organisations to access patient records	Planning & Delivery

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COMMISSIONING TEAM KEY

MH - Mental Heath Services

CYP - Children & Young People's Services

UC - Urgent Care

PC - Planned Care

COMM - Community Services

PC - Planned Care

PRIM. C - Primary Care