Brighton & Hove City Council

Health Overview & Scrutiny Committee

Date:	**23 April 2025**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:**Fowler (Chair), Wilkinson (Deputy Chair), Cattell, Evans, Galvin, Hill, Hogan, Mackey and O'Quinn **Co-optees** Mo Marsh (Older People's Council), Nora Mzaoui (CVS) and Geoffrey Bowden (Healthwatch)
Contact:	**Giles Rossington** Scrutiny Manager 01273 295514 giles.rossington@brighton-hove.gov.uk

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AGENDA

PART ONE **Page**

32 PROCEDURAL BUSINESS

(a) **Declaration of Substitutes:** Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) **Declarations of Interest:**

(a) Disclosable pecuniary interests;
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare:
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members should seek advice from the committee lawyer or administrator preferably before the meeting.

(c) **Exclusion of Press and Public:** To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: *Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls and on-line in the Constitution at part 7.1.

33 MINUTES 7 - 12

To consider the minutes of the previous Health Overview & Scrutiny Committee meeting held on 29 January 2025, (copy attached).

34 CHAIR'S COMMUNICATIONS

35 PUBLIC INVOLVEMENT 13 - 14

There is a public question from Mr Adrian Hill (copy attached).

36 MEMBER INVOLVEMENT

To consider the following matters raised by Members:

(a) **Petitions:** To receive any petitions submitted to the full Council or to the meeting itself.
(b) **Written Questions:** A list of written questions submitted by Members has been included in the agenda papers (copy attached).
(c) **Letters:** To consider any letters submitted by Members.
(d) **Notices of Motion:** To consider any Notices of Motion.

37 PLANS FOR CAPITAL DEVELOPMENT OF ROYAL SUSSEX COUNTY HOSPITAL EMERGENCY DEPARTMENT

Report of the Chair of the Health Overview & Scrutiny Committee (to follow).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

38 NHS PALLIATIVE CARE OFFER FOR PEOPLE IN BRIGHTON & HOVE 15 - 32

Report of the Chair, Health Overview & Scrutiny Committee (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

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FURTHER INFORMATION
For further details and general enquiries about this meeting contact Luke Proudfoot, (01273 295514, email giles.rossington@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

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Date of Publication - Tuesday, 15 April 2025

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 29 JANUARY 2025

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Fowler (Chair)

Also in attendance: Councillor Wilkinson (Deputy Chair), Baghoth, Evans, Galvin, Hill, Hogan, Mackey and O'Quinn

Other Members present: Mo Marsh (OPC), Geoffrey Bowden (Healthwatch), Nora Mzaoui (CVS)

PART ONE

25 PROCEDURAL BUSINESS

25(a) substitutes

25.1 Cllr Grimshaw attended as substitute for Cllr Cattell.

25(b) Declarations of Interest

25.2 There were no declarations of interest.

25(c) Exclusion of Press & Public

25.3 The press & public were not excluded from the meeting.

26 MINUTES

26.1 The minutes of the 20 November 2024 committee meeting were agreed.

27 CHAIR'S COMMUNICATIONS

27.1 The Chair gave the following communications:

We have 2 items on the agenda today. The first item is an update report on trans healthcare, focusing on the Sussex Gender service. This is a pilot scheme that provides specialist gender services for Sussex residents who would previously have had to travel to London or another location outside of Sussex, often facing multi-year waits for access. When HOSC last looked at

trans health, this service was in the process of being launched. It has now been in operation for a little over a year, so we should be in a good place to assess how well it is working.

The report will be presented by Sussex Partnership NHS Foundation Trust who are the service providers. There is no presentation on other aspects of trans health services today, but if members have questions on other services, NHS colleagues will try to answer them at the meeting, or in writing.

The second item for consideration is a report on access to GP services in the city. I asked specifically for this report as I know that getting a GP appointment is a major issue for people living in Brighton & Hove.

On Monday, I visited the Royal Sussex County Hospital where I was shown around the Emergency Department by the lead nurse and doctor. They talked about the daily challenges they face and were proud of local innovations and improvements that have reduced corridor care this winter. But they were clear the main cause of corridor care is delayed discharges due to availability of other health and social care services they do not provide.

As our committee has heard before, every day the hospital has dozens of patients in ward beds who no longer need hospital treatment - if just a proportion of these people could leave hospital on their discharge date, the ED staff said the problem of corridor care would no longer exist. I also visited the new Surgical Assessment Unit, which is the first area to be completed in the £50m redevelopment of the Emergency Department. Colleagues talked me through the plans which will see the whole department modernise and expand over the next three years.

While at the hospital, I wanted to speak with chief executive Dr George Findlay about ongoing negative media coverage related to Operation Bramber. Obviously, we know George cannot comment on the inquiry itself, but he fully recognises, and shares our concerns about the impact this has on patients. George provided assurance about the quality and safety of care patients receive, as well as progress being made on the Improvement Plan they brought to HOSC last summer.

I am asking the Trust to return to committee soon to provide us with an update, and to answer any questions you may have.

26.2 Cllr Hill noted that Sussex Partnership NHS Foundation Trust had previously agreed to share with the committee an equality impact assessment on its plans to shut city acute dementia beds, but this had still not been circulated. The Chair agreed to contact the Trust to request this be shared.

28 PUBLIC INVOLVEMENT

28.1 There were no public involvement items.

29 MEMBER INVOLVEMENT

29.1 There were no member involvement items.

30 TRANS HEALTHCARE: SUSSEX GENDER SERVICE

30.1 This item was presented by Dr Kat Allen, Consultant Clinical Psychologist and Clinical Lead, Sussex Gender Service (SGS) Pilot, Sussex Partnership NHS Foundation Trust (SPFT); Dr Julia Rutherford, SPFT; and by Dr Andy Hodson, Deputy Chief Medical Officer, NHS Sussex.

30.2 Dr Allen outlined key aspects of the SGS to the committee:

- The pilot period is for 2 years with the potential to extend for an additional year
- The SGS was mobilised between March and August 2023
- The SGS went live in September 2023, with services operating at full capacity by July 2024
- SGS receives support from an existing gender service, the Nottingham Centre for Transgender Health
- The SGS partners with The Clare Project to deliver extensive and ongoing community engagement
- The SGS will see around 1300 service users across the life of the pilot
- The SGS operates a 2-stage assessment process, with an initial appointment with a nurse, and a follow-up appointment with either a GP or a clinical psychologist as appropriate
- 259 stage 1 appointments and 220 stage 2 appointments were delivered in the first year of operation
- The SGS was intended, in part, to help tackle the very long waiting lists for gender services. This has been successful, with average waits now down to around 3.5 years from 5 years plus when the SGS began.

30.3 Members asked a number of questions on issues including:

- How people waiting for assessment could access hormone therapy
- What will happen to the SGS when the lengthy waiting list has been successfully reduced
- Where patients can access gender surgery
- How the impacts of waiting a long time for assessment are supported and how the mental health of people waiting for assessment is monitored
- Co-working with existing gender services to which people on the Sussex waiting list were originally assigned
- Local GP support for trans people, including people on the waiting list
- How the Nottingham gender service supports the SGS
- How people on the SGS waiting list can access fertility preservation services
- The process by which the pilot can be made permanent
- The details of the SGS assessment process
- The percentage of people on the waiting list who choose not to progress with gender reassignment
- The number of people using the service and whether people move to Sussex in order to access services
- The age at which hormones may be prescribed
- The gender split in the younger cohort using the SGS
- Prescription practices
- The minimum age of referral to the SGS
- Links between the SGS and children and young people services

- What happens to people on the SGS waiting list who move out of Sussex
- How GPs who take on a large number of trans patients are reimbursed

30.4 Dr Allen agreed to provide additional information on the gender split of SGS patients; the percentage of patients who choose not to progress; the details of the holistic assessment process; and demographic information on SGS patients.

30.5 Cllr Hill had a number of questions but was unable to ask them all as the presenters had to leave. She expressed disappointment at this but agreed that she would submit some questions in writing. Cllr Hill made some comments from a personal perspective as a trans person who uses local GP services, but who is not on the SGA waiting list. Cllr Hill noted:

- That using fertility preservation services may require delaying hormone treatment. It is important that the SGS supports local GPs to understand this issue.
- Some trans people manufacture their own hormones – it is important that services are alert to this and have a process for moving people to proper prescriptions
- waiting lists remain a major concern – long waits can have major negative impacts on service users, including suicide
- There is concern in the local trans community about unsupportive GPs and about the Integrated Care Board's (ICB) decision to cease running the Trans Community Board, and it would be helpful to have information in public about this decision.

Dr Hodson replied that the ICB had suspended the Trans Community Board as it is currently reviewing how best to embed people with protected characteristics into governance processes. A report back is due at the end of February; Dr Hodson will check whether this can be made public.

30.6 RESOLVED – that the report be noted.

31 ACCESS TO GP SERVICES IN BRIGHTON & HOVE

31.1 This item was presented by Garry Money, Director of Primary Care Commissioning & Transformation at NHS Sussex; Kate Symons, Deputy Director of Primary Care; and by Dr Andy Hodson, a local GP and NHS Sussex Deputy Chief Medical Officer.

31.2 Mr Money told the committee that:

- There are 31 GP practices in Brighton & Hove, sharing 333,619 registered patients
- The patient list has an annual growth rate of around 0.7%
- There is a large variation across the city in terms of GP practice size
- GP appointments dipped during the pandemic but have subsequently recovered and are now well above pre-pandemic levels, with a 5% year on year increase

- The number of GP appointments per resident in Brighton & Hove is slightly lower than both the England and the SE average
- There are significant variations in the performance of practices across the city, and while some of this may be explained by demographics or the specialist nature of some practices, reducing unwarranted variation is a priority
- Other priorities include reducing health inequalities and finding a solution to the 8am rush for appointments
- There is positive news in terms of workforce, which is up 8.3% in the past year
- There is a national push for enhanced access to GP services (outside of core hours), and Brighton & Hove is performing well in this respect
- There is a national move to a 'modern general practice' model where GPs are supported by a wide workforce mix. This is supported locally but is not a universally popular model with patients.

31.3 Members asked questions on issues including:

- The benefits of digital services
- Digital exclusion
- Whether being a city with a high cost of living impacts the recruitment of GPs and GP practice roles
- Continuity of care
- GP recruitment and retention
- The increasing use of pharmacists and GP associates and whether these roles are always used appropriately
- How information on the breadth of services available at GP practices is communicated to the public
- The role of GPs and pharmacists in supporting timely and effective hospital discharge
- The impact on GP practices of recent changes to employer National Insurance contributions
- The availability across city GP practices of enhanced telephony, including the facility for call-back
- Remote appointments
- The role of GPs in supporting timely hospital discharge
- The use of physician associate roles.

31.4 RESOLVED – that the report be noted.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Agenda Item 35

Public Questions

Question from Mr Adrian Hill

Brighton & Hove has some of the worst air quality in the UK. However the city has some of the most relaxed regulations on emissions.
Studies show that ⅓ of all asthma cases in cities similar to ours are caused by air pollution. Air pollution is also a significant cause of heart disease, lung cancer, diabetes, developmental problems in children and dementia.
Could the NHS do more to request that the council implement air quality improvements effectively without delay?

Brighton & Hove City Council

Scrutiny Report Template

Health Overview & Scrutiny Committee

Agenda Item 37

Subject: **NHS Palliative Care Offer for People in Brighton & Hove**

Date of meeting: **23 April 2025**

Report of: **Chair of the Health Overview & Scrutiny Committee**

Contact Officer: **Name: Giles Rossington, Scrutiny Manager**

Tel: 01273 295514
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: (All Wards);

Key Decision: No

For general release

1. Purpose of the report and policy context

1.1 This report provides an overview of NHS palliative care and hospice provision for people living in Brighton & Hove. It was compiled by NHS Sussex Integrated Care Board, NHS Providers, and Martlets Hospice (who receive a grant from NHS Sussex). (see Appendix 1).

1.2 The report is provided in response for a request from HOSC members for more information on the palliative care available to city residents.

2. Recommendations

2.1 That the Health Overview & Scrutiny notes the contents of this report and its Appendix.

3. Context and background information

3.1 Palliative and end of life care is care provided to people nearing the end of their lives or with progressive illnesses. This includes care delivered in hospitals, but also via primary care and community services. Appendix 1 contains a paper jointly authored by NHS Sussex, which commissions palliative and end of life services; and service providers including University Hospitals Sussex NHS Foundation Trust; Sussex Community NHS Foundation Trust; and Martlets.

4. Analysis and consideration of alternative options

4.1 Not relevant for this report for information.

5. Community engagement and consultation

5.1 None directly. Community & Voluntary Sector partners have been involved in the drafting of Appendix 1 to this report.

6. Financial implications

6.1 No financial implications have been identified as arising from this report, which is for information only.

Name of finance officer consulted: Ishemupenyu Chagonda Date consulted (14/04/2025):

7. Legal implications

7.1 No legal implications have been identified as arising from this report, which is for noting only.

Name of lawyer consulted: Victoria Simpson Date consulted 7.04.25

8. Equalities implications

8.1 None directly for this information report.

9. Sustainability implications

9.1 None directly for this information report.

10. Health and Wellbeing Implications:

10.1 None directly for this information report.

Other Implications

11. Procurement implications

11.1 None directly for this information report.

12. Crime & disorder implications:

12.1 None identified.

13. Conclusion

13.1 Members are asked to note the contents of this report outlining NHS palliative care services for people living in Brighton & Hove.

Supporting Documentation

1. Appendices

1. Information on NHS palliative care in Brighton & Hove provided by health and care system partners.

Report to	Brighton and Hove Health Overview and Scrutiny Committee (B&H HOSC)
Meeting date	23 April 2025
Report Title	NHS Palliative Care Offer to Brighton and Hove residents
Presenters	Lola Banjoko - Deputy Chief Integration & Primary Care Officer and Director of Joint Commissioning, NHS Sussex supported by: • Steve Bass- Lead Nurse, Palliative and End of life Care, University Hospitals Sussex NHS Foundation Trust • Lisa O'Hara- Nurse Consultant Palliative & End of Life Care • Lisa Barrott-Chief of Nursing Care, Southern Hospice Group • Tiritega Mawaka-Deputy Director, All-Age Continuing Care, NHS Sussex
Authors	• Helen Cobb-Senior Manager, Community Commissioning and Transformation, NHS Sussex • Sarah Pearce-Deputy Head, Community Commissioning and Transformation, NHS Sussex • Stephen Bass-Lead Nurse, Palliative and End of life Care, University Hospitals Sussex NHS Foundation Trust • Simone Ali-Medical Director, & Consultant in Palliative Medicine, Martlets Hospice • Amanda Fadero-Chief Executive Officer, Southern Hospice Group • Stuart Palma-Director of All-Age Continuing Care, NHS Sussex • Lisa O'Hara- Nurse Consultant Palliative & End of Life Care • Sussex Community Foundation trust • Ed Cassidy-Senior Contracts Manager, Sussex Community NHS Foundation Trust

Summary:

This paper has been developed following a request by the Brighton and Hove HOSC.

The paper outlines the ICB's statutory responsibilities in relation to Palliative and End of Life Care (PEoLC) and the Palliative Care offer to B&H residents by Providers working in the B&H system that receive NHS funding and how these organisations work collaboratively to support patients with PEoLC needs.

NHS Palliative Care offer to Brighton and Hove residents

1. Introduction/ Background

As a system in 2022 we agreed our system strategy *Improving Lives Together* building on the Health and Wellbeing Strategies we have in place across Brighton and Hove, East Sussex and West Sussex that focus on the priorities across our local populations. Our five-year strategy sets out our ambition for our population and the areas that will make the biggest positive difference to people's lives that can be best achieved by working across the whole of Sussex.

These are:

- A new joined-up community approach to health and care
- Growing and developing our workforce
- Improving the use digital technology and information
- Maximising the power of partnership working

We now have a better opportunity to make our ambition a reality because of the different way that we – the organisations responsible for planning, providing, supporting and influencing health and care - are working together. This includes Palliative End of Life Care (PEoLC)

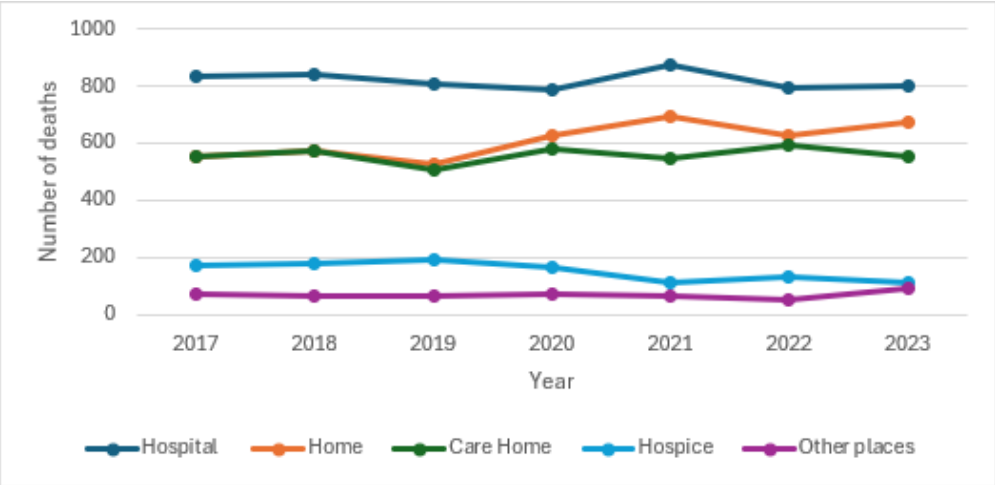
The ICS has a key role to play in ensuring that people with palliative and end of life care needs can access and receive high quality personalised care and support. Health and care partners have a responsibility to ensure that the palliative and end of life care needs of people of all ages, with progressive illness or those nearing the end of their lives, and their loved ones and carers, receive the care and support they need to live and to die well. This includes addressing health inequalities for PEoLC, by improving equity of access to services and reducing inequity of outcomes and experience.

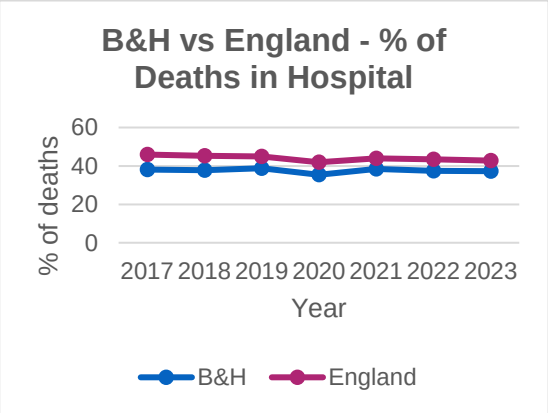
2. Overview

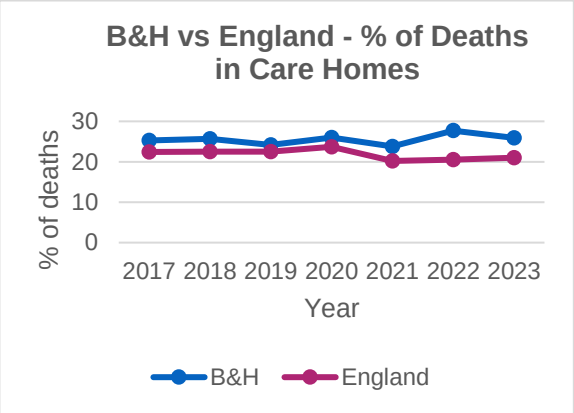
In Brighton and Hove there are, on average, circa 2,100 deaths per year.

1

Annual deaths by place of death: Brighton and Hove:







It is widely recognised that people prefer to die at home or in a community setting of their choice. These graphs demonstrate that Brighton & Hove benchmarks well against the England average at providing PEoLC outside hospital, which therefore means people are more likely to die in their preferred place of death.

Despite this, we always recognise that more can be done to improve PEoLC and coordinate care across system partners.

2

3. Priority Focus

In 2022, health and care partners recognised the PEoLC programme as a priority area of focus and a Sussex Palliative and End of Life Care (PEoLC) all age Programme Oversight Group was established. This is a multi-stakeholder group with wide reaching representation across the Sussex system.

A Strategic Action plan covering 2022-25 was developed with the following vision:

'Our collective aim in Sussex is to make the last stage of a person's life as good as possible, through working together confidently, honestly, and consistently to help each individual and the people important to them'

The NHS England (NHSE) Ambitions framework was developed by a partnership of national organisations across the statutory and voluntary sectors. It sets out NHSE's vision to improve end of life care through partnership and collaborative action between organisations at local level throughout England.

There are six ambitions:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help

In 2022 an exercise was undertaken to map the Sussex system against these ambitions. This was used to inform the development of the Sussex ICS PEoLC Programme Strategic Action Plan for 2022-2025.

2. Current Services

2.1 Primary Care

NHS Sussex commissions a Frailty and End of Life Locally Commissioned Service (LCS), which supports the identification of people with severe frailty and those living in the last year of life. Those identified should be offered personalised care and support planning, including Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) where appropriate.

Following the introduction of the LCS over 95% of Brighton & Hove GP Practices have signed up to provide this LCS, and the number of people on a GP practice palliative care register in B&H has increased from 321 in 2009/10 to 983 in 2023/24.

3

The LCS encourages discussion regarding the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) at an earlier stage.

The ReSPECT process aims to ensure that a person's clinical care wishes are known, so that in a future emergency where they may not have capacity or be able to express their choices these are already known in the person's ReSPECT plan. The ReSPECT process is intended to respect both patient preferences and clinical judgement.

There have been a variety of educational and training events regarding ReSPECT. There are resources available on the ICS website at: https://www.sussex.ics.nhs.uk/professional-guidance/carers/care-planning/respect/ which are accessible to patients and system partners/providers. There are resources specifically for patients and their families at: https://www.sussex.ics.nhs.uk/your-care/emergency-care-plan/#h-respect-resources These pages contain information about the ReSPECT process and how it supports patient care.

The aim is to support the involvement of patients, carers and families, and system partners in the use of ReSPECT in practice, and in training and education around ReSPECT and its place in End-of-Life care. There is a focus on admission avoidance for end-of-life patients.

2.2 University Hospitals Sussex NHS Foundation Trust

End of life care (EoLC) is one of the core services provided by University Hospital Sussex NHS Foundation Trust (UHSx). EoLC is provided on the basis of patient need irrespective of diagnosis.

Referrals to the specialist palliative care team (SPCT) are accepted for patients who:

- Have active, progressive, advanced disease of any diagnosis with a probable prognosis of less than 12 months.
- Have a complex level of need exceeding the skills and/or capacity of the current caring team and are over 18 years of age
- Patients that are within the last days of life

The UHSx SPCT provides support for:

- multiple, complex or refractory physical symptoms
- complex end of life care
- difficult social, psychological and spiritual issues
- complex family and carer needs requiring specialist support
- discharge planning when the situation is complex or to facilitate transfer to hospice for appropriate patients
- support and advice to ward teams in all aspects of caring for patients at the end of life

- support with the rapid discharge of patients who have been identified as being in the last days to short weeks of life whose preferred place of care is not hospital

UHSx has recently implemented a digital end-of-life-care plan which ensures that patients nearing the end of life are assessed, their symptoms reviewed, and appropriate care provided in a timely manner, with support from the SPCT.

UHSx PEoLC Strategy 2021-27:

Patient	Improve SPCT's response to those recognised as dying and symptomatic, thus improving Patient/Carer experience.
People	Improve parent teams' confidence in managing care of the dying and associated symptoms, thus improving staff commitment to excellent care
Quality	Improve UHSx's ability to recognise deterioration from life-limiting illness and acknowledge unavoidable death and how this impacts on mortality rates.
Sustainability	Improve SPCT productivity, in triage and allocation of workforce.
Systems & Partnerships	Earlier recognition of deterioration from life-limiting illness, with the potential to promote earlier EoLC transfer of care to community setting.
Research & Innovation	Create an innovative and evidence-based approach to improve care of the dying in an acute setting that is replicable in other organisations.

The SPCT supports discharge from hospital:

- The SPCT works closely with the hospital discharge co-ordinators and ward teams to support patients to achieve their preferred place of care and death
- On discharge patients will be referred to appropriate community teams including community nursing services
- Referral to Martlets hospice for patients with specialist palliative care needs

The SPCT has a daily MS Teams meeting with Martlets to discuss and triage referrals for specialist palliative care on Martlets in-patient unit.

In Q3 2024/25 the SPCT supported 1196 newly referred patients within the hospital. During this time the SPCT provided specialist support for the care of 546 patients who died in UHSx.
In the same period the SCPT supported 410 discharges:

- 53% returned home
- 20% to a care home
- 12% to a hospice in-patient unit
- 15% to other destinations

Approximately 40% of the UHSx SCPT caseload is at Royal Sussex County Hospital.

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2.3 Sussex Community NHS Foundation Trust (SCFT)

SCFT provides palliative and end of life care in people's own homes, for those who are approaching end of life and are likely to die within the next 12 months. Sussex Community NHS Foundation Trust (SCFT) strives to ensure the last few months, weeks, or days of a person's life are as dignified and comfortable as possible.

Our end-of-life strategy is aligned to national ambitions with the following objectives:

- each person is seen as an individual
- each person gets fair access to care
- maximising comfort and wellbeing
- care is co-ordinated
- all staff are prepared to care
- each community is prepared to help

SCFT provides palliative care in B&H in collaboration with partner agencies including general practice, Martlets, UHSx, Macmillan, South East Coast Ambulance Service (SECAmb), Continuing Healthcare and Adult Social Care to enable patients to return home from hospital as quickly as possible and to avoid unwanted admissions to hospital where possible.

Palliative patients in B&H who are referred to SCFT are supported by a 24/7 service including community nurses, homeless health inclusion team, Urgent Community Response, overnight nursing, Virtual wards, SCFT specialist services, Enhanced Health in Care Homes matrons (if the patient lives in a care home) and our intermediate care units. These teams work collaboratively to ensure patients receive individualised and coordinated care, in their preferred place of care wherever possible.

All adult community nursing teams in SCFT have a weekly meeting with their local hospice to discuss palliative patients on their caseloads. This allows end of life care to be provided by the most appropriate team and ensures that these organisations are able to mutually support one another. This ensures that palliative patients always receive an excellent service tailored to their needs. The Martlets community palliative care team meets the SCFT community nursing teams every Thursday afternoon. SCFT community teams also attend Gold Standard Framework (GSF) meetings led by Primary Care to discuss and plan for patients approaching end of life.

Patients receiving end of life care from SCFT have an individualised end of life care plan, ensuring advance planning is in place and the patient wishes and preferences are clearly documented. This holistic assessment document supports teams to identify the needs of a person at the end of their life and respond to these needs appropriately.

SCFT work alongside colleagues in primary care to ensure that patients at the end of their life have a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) plan detailing what matters to them. This plan contains important information about

preferred place of care as well as any preferences regarding admission to hospital and resuscitation. Staff at SCFT receive training in both understanding of the ReSPECT process and how to respond appropriately to a patient with a ReSPECT plan in an emergency. SCFT have a dedicated ReSPECT Lead who delivers level 2 ReSPECT training, which is mandatory for all band 6 and above clinicians including all community nursing teams.

SCFT has a dedicated Nurse Consultant in Palliative & End of Life Care (PEoLC) who sets the local agenda for PEoLC across the SCFT localities, aligned to the national ambitions document. They ensure high quality care is delivered working in partnership with other organisations and service users.

The SCFT end of life training facilitator provides palliative care training to nursing staff in nursing homes in Brighton and Hove.

2.4 Martlets Hospice

Martlets is the sole provider of both community and hospice in-patient-based specialist palliative and end of life care to adults living in Brighton & Hove.

Martlets receives a grant towards their running costs from NHS Sussex, but the majority of their income comes from community fund raising, retail and major donors.

Martlets offers specialist assessment, advice and support to patients who are 18 years and over and who have advanced, progressive and life-limiting illness (whether due to cancer or a non-cancer diagnosis) and who require complex pain or other physical symptom control. Martlets also offers complex psychosocial assessment and support to patients and their families/carers, specialist help with rehabilitation or adjustment to deteriorating function and/or specialist end of life care and support.

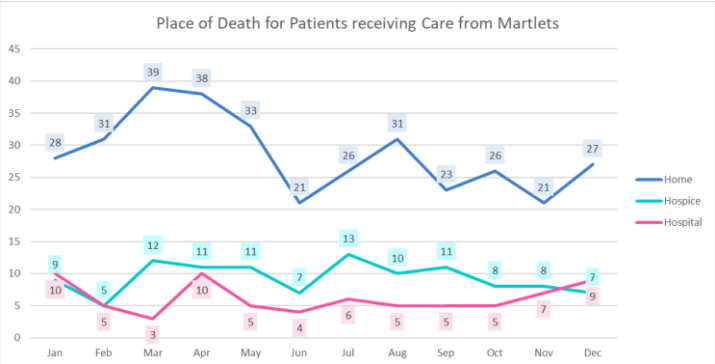
This includes supporting complex advance care planning discussions by working with the primary care clinical team in charge of care to facilitate avoidance of admission to the acute setting.

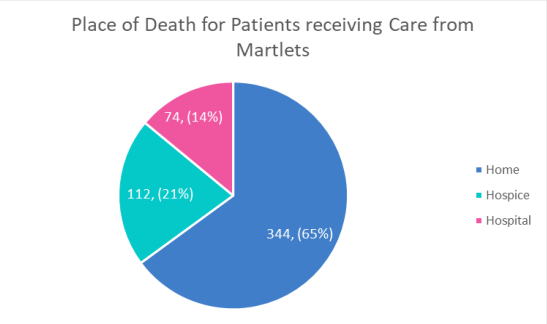
Martlets' specialist multi-disciplinary team, comprising doctors, nurses, physiotherapy and occupational therapy team, social workers, counsellors, spiritual care lead, clinical admin and volunteers, conduct face to face holistic, patient-centred assessments in the home setting, including care homes, in their out-patient clinic, or on the specialist in-patient unit. They also provide 24/7 specialist clinical telephone advice, with access to a Consultant in Palliative Medicine, via their Hub for patients and their families and for health care professionals.

In addition, Martlets provides Well-Being and Supportive Services to enable patients and their families to manage the social, emotional and practical impacts of their illness, and to prevent the development of a crisis situation. Martlets offers pre- and post-bereavement

support to families and carers of all patients who are or have been under their care.

Place of death for patients receiving care from Martlets, 2023:





Whilst referrals largely come from GPs, PCN teams and the hospital team at RSCH, Martlets also works closely and effectively with other providers such as SECAmb, IC24, care home teams and social care.

The service aims to work in collaboration with colleagues in primary and community care and across hospital and other care settings to enable people with complex needs to die in their preferred place of care with dignity and with optimal symptom control.

Martlets is now part of Sussex Hospice Group (with St Barnabas House and Chestnut Tree House) and their subsidiary company, Martlets Care, provides personal care to a range of clients across Brighton & Hove, both privately and state funded. Home care is centred around the needs of the client, and adults of all ages and life stages are supported.

2.5 All-Age Continuing Care (AACC), NHS Sussex

Background

In the context of NHS Continuing Healthcare (CHC), "Fast Track" funding refers to a streamlined process for individuals with a rapidly deteriorating condition, typically those nearing the end of their life. The purpose of CHC Fast Track funding is:

- to expedite the process of securing NHS Continuing Healthcare funding for individuals in urgent need of care
- to ensure that people with rapidly deteriorating conditions receive the necessary care and support without unnecessary delays
- To ensure rapid funding, and the provision of care in the most suitable environment. This is decided taking into account the patient's wishes, best interests, safety, sustainability and resource.

The provision of Fast Track (FT) CHC funding is either in a 'placement' or provided in the person's home.

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Placements
AACC commissions Nursing Home beds for those with FT CHC funding and has a robust marketing and contracting framework in place, to ensure the safety, quality and best use of resources, when commissioning these beds.

The NHS Sussex All-Age Continuing Care Service has a Sussex wide Nursing Home Any Qualified Provider (AQP) Contracting Framework in place. For providers to have access to this framework, they must demonstrate:

- High quality, safe provision of care. This includes regulator ratings, such as the CQC, and any provider concerns
- Providers agree to sign up to a fair, and affordable weekly charge for a bed – this ensures placements are sustainable and best value for the taxpayer

In late 2024, AACC agreed to block purchase bed capacity at Martlets, to provide non-specialist nursing care services for CHC Fast-track funded EoLC patients, as a proof-of-concept approach. 6 beds were commissioned for this purpose. This arrangement supports faster transfer of patients, from hospital/community to a hospice bed.
Following the success of this proof-of-concept pilot this will be rolled out to other hospices across Sussex.

This approach ensures, high quality provision of end-of-life care, for patients in a rapidly deteriorating phase of life, whilst providing a stream of long-term financial security for hospices, by providing funding guarantees through long term contracts.
This agreement ensures a rapid, streamlined process, from the community/hospital to the hospice setting – improving patient experience and outcomes.

Domiciliary 'Home-based' care
CHC commissions domiciliary, home care, packages for patients who are rapidly deteriorating. Once a patient is confirmed as eligible, CHC 'broadcast' to domiciliary care providers, who will assess whether they can meet the needs of the patient.
CHC has a robust quality assurance framework in place for providers, to ensure they meet the highest standards of quality and safety.

In a recent development, CHC are working on a proof-of-concept with the subsidiary arm of Martlets Hospice, Martlets Care, to provide a high quality, safe and effective service to those Brighton & Hove residents with CHC FT funding in place, requiring care at home. Being based at Martlets, this benefits from close working with the Hospice teams, with rapid transfer from home to the hospice if required. A plan is in place for Martlet's Care to provide care to more patients, as they grow a sustainable workforce to meet the need.

3. Volunteers

The Royal Sussex County Hospital, supported by the Friends of Brighton and Hove Hospitals, has launched "*A Friend In Need"*, a new volunteer service dedicated to providing companionship and emotional support to patients, and their loved ones, at the end of their life. In the first three months, 13 volunteers visited nearly 100 patients, offering a comforting presence and a listening ear to those in need. The initiative has received overwhelmingly positive feedback, with patients and families expressing profound gratitude for the comfort and companionship provided. Volunteers, including retired individuals and professionals, find the experience fulfilling and the service is highly valued by hospital staff for enhancing the quality of end-of-life care. For more information, visit: www.uhsussex.nhs.uk/news/selfless-volunteers-bring-comfort-to-end-of-life-patients-in-brighton/.

At Martlets, volunteers play a vital role in the delivery of counselling, therapy and wellbeing, spiritual care and chaplaincy services. Currently this includes several volunteer counsellors who provide 10 additional sessions per week to patients and their families, a bereavement support home visitor, the Compassionate Neighbours scheme with 32 volunteers across Brighton & Hove, 21 Wellbeing Group Volunteers supporting a variety of complementary therapies being delivered to Martlets patients and their carers,10 volunteer drivers who support patients and their carers to access groups and complementary therapy services, and 2 volunteers who support Martlets' chaplain to provide patients on the inpatient unit with spiritual support. Martlets could not provide all these services to patients and their families without their volunteer workforce, and are looking at further opportunities across their hospice sites to further utilise their volunteers' vital input.

4. Clinical Case Study

Clinical Case Study illustrative of the joint working between providers of PEoLC in Brighton and Hove.

A patient with advanced cancer underwent intensive treatment during 2021, the patient responded to treatment and was stable until early 2023 when a recurrence was diagnosed.

The patient expressed a wish to remain at home for as long as possible.

Over a period of 3 months the patient had multiple hospital admissions for falls, sepsis, acute kidney injury, and self-neglect, however a wish to remain at home as much as was possible remained strong. To facilitate this, SCFT Community Nursing, Rehab Services, and Urgent Community Response were involved, the patient had inpatient rehab, and CareLink installed.

During their regular visits SCFT Community Nurses continued to build a relationship with the patient, enabling advance care planning discussions to take place. A ReSPECT plan

was completed confirming the patient's wish to be cared for at home with preferred place of death (PPD) being at home.

Following a subsequent hospital admission, the ReSPECT plan was updated with preferred place of death as hospice in-patient unit and, remaining at home for her on-going care.

Martlets and SCFT agreed that SCFT's community nurses provided ongoing face-to-face care with Martlets 24/7 Hub providing specialist clinical advice regarding complex pain control to the SCFT Community Nurses and GP as needed, due to the patient's reluctance to engage with new services. Subsequently the patient was admitted to hospital and was reviewed by the Hospital Palliative Care Team (HPCT). In line with patient wishes, discharged back home Dec 2024, with an increased package of care.

Despite these plans a further A&E attendance was clinically indicated. Following review by the HPCT and discussion with the patient, it was agreed that the patient be discharged to Martlets for specialist pain and symptom management, as well as social, psychological and spiritual support, as the most appropriate treatment environment aligned to the patient's wishes.

The patient was cared for and the family supported appropriately during the hospice admission. The patient died peacefully, in their preferred place of death, and the family member was offered bereavement support and follow up by Martlets.

Despite the clinical and social challenges presented, the patient's wishes and preferences regarding their end-of-life care were respected by all services (hospital, community and hospice), and through collaboration and close partnership-working, care was individualised and preferred place of death achieved. An awareness of, and respect that an individual's wishes and preferences can change over time were reflected in the changes to the Care and ReSPECT plans.

5. Looking to the Future

Organisations within the Sussex Health and Care Partnership commenced their journey to work in a joined-up way to better meet the needs of each local community in 2022 when collectively we agreed our system strategy, *Improving Lives Together*.

Aligned to the system strategy *Improving Lives Together*, the six hospice charities in Sussex have come together strategically to work alongside the NHS and statutory partners. The charities are:

- St Wilfrid's Hospice, Chichester
- Southern Hospice Group (St Barnabas House, Martlets, Chestnut Tree House)
- St Peter and St James's Hospice

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- St Catherine's Hospice
- St Wilfrid's Hospice, Eastbourne
- St Michael's Hospice, Hastings and Rother

September 2024 the six hospice charities formed the Sussex Hospice Alliance (SHA) supported by NHS Sussex.

The key strategic drivers for the Sussex Hospice Alliance are:

- Meeting the goals of *Improving Lives Together*, the strategy for NHS Sussex, with specific reference to end-of-life care and support, and its delivery within Integrated Community Teams – Multidisciplinary Teams working across organisations
- Achieving the goals of the Sussex Health and Care PEoLC Strategic Action Plan
- Meeting statutory responsibilities for Integrated Care Boards (ICB) for PEoLC set out in the Health and Social Care Act (2022)
- Achieving strategic goals and charitable aims of individual Sussex hospices in serving their local communities
- Reducing health inequalities in PEoLC

In 2024/25 the Sussex Hospice Alliance successfully trialled 3 'proof of concept' models:

- Bedded care for Discharge-to-Assess Pathway 2 patients
- Bedded care for patients eligible for AACC Fast-track funding
- Provision of AACC funded domiciliary care

In 2025/26 the SHA plans to:

- Commission AACC fast-track funded beds across the hospices in the Alliance
- Assist in the development of virtual health for PEoLC patients
- Embed as a key partner in Integrated Care Teams (ICTs)

NHS Sussex focus for 2025/26 is to improve system working and enable greater impact with partners by delivering integrated care at Neighbourhood level.

6. Conclusion

This paper has outlined the ICB's statutory responsibilities in relation to Palliative and End of Life Care (PEoLC) and the Palliative Care offer to Brighton & Hove residents, illustrating how these organisations work collaboratively to support patients with PEoLC needs.

The ambition is to continue to work in partnership to provide high quality care, where possible in the care setting of the patient's choosing, delivering personalised and joined-up End of Life care. This approach aligns into the developing Neighbourhood and Integrated Community Teams.