Brighton & Hove City Council

BRIGHTON & HOVE CITY COUNCIL MEETING

Date: **19 December 2019**

Time: **4.30pm**

Venue **Council Chamber, Hove Town Hall**

Members: **Councillors:** Phillips (Chair), Robins (Deputy Chair), Simson, Allcock, Appich, Atkinson, Bagaeen, Barnett, Bell, Brennan, Brown, Childs, Clare, Davis, Deane, Druitt, Ebel, Evans, Fishleigh, Fowler, Gibson, Grimshaw, Hamilton, Heley, Henry, Hill, Hills, Hugh-Jones, Janio, Knight, Lewry, Littman, Lloyd, Mac Cafferty, Mears, McNair, Miller, Moonan, Nemeth, Nield, O'Quinn, Osborne, Peltzer Dunn, Pissaridou, Platts, Powell, Rainey, Shanks, C Theobald, Wares, West, Wilkinson, Williams and Yates

Contact: **Mark Wall**
Head of Democratic Services
01273 291006
mark.wall@brighton-hove.gov.uk

Agendas and minutes are published on the council's website www.brighton-hove.gov.uk. Agendas are available to view five working days prior to the meeting date.

Electronic agendas can also be accessed through our meetings app available through www.moderngov.co.uk

This agenda and all accompanying reports are printed on recycled paper

AGENDA

PART ONE **Page**

47 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 Monitoring Officer or Democratic Services Officer preferably before the meeting.

48 MINUTES **9 - 60**

To approve as a correct record the minutes of the last Council meeting held on the 24 October 2019.

Contact Officer: *Mark Wall* *Tel: 01273 291006*
Ward Affected: *All Wards*

49 MAYOR'S COMMUNICATIONS.

To receive communications from the Mayor.

50 TO RECEIVE PETITIONS AND E-PETITIONS.

Petitions will be presented by Members and/or members of the public to the Mayor at the meeting.

51 WRITTEN QUESTIONS FROM MEMBERS OF THE PUBLIC.

A list of public questions received by the due date of 12noon on the 13 December 2019 will be circulated separately as part of an addendum at the meeting.

52 DEPUTATIONS FROM MEMBERS OF THE PUBLIC.

A list of deputations received by the due date of 12noon on the 13 December 2019 will be circulated separately as part of an addendum at the meeting.

53 PETITIONS FOR COUNCIL DEBATE 61 - 62

Petitions to be debated at Council. Report of the Monitoring Officer.

(1) **Rejection of the usage of the terms 'Duke and Duchess of Sussex'.** Lead petitioner Charles Ross.

Contact Officer: Mark Wall Tel: 01273 291006
Ward Affected: All Wards

54 CALL OVER FOR REPORTS OF COMMITTEES.

(a) Call over (items 57-59) will be read out at the meeting and Members invited to reserve the items for consideration.

(b) To receive or approve the reports and agree with their recommendations, with the exception of those which have been reserved for discussion.

(c) Oral questions from Councillors on the Committee reports, which have not been reserved for discussion.

55 WRITTEN QUESTIONS FROM COUNCILLORS. 63 - 74

A list of the written questions submitted by Members has been included in the agenda papers. This will be repeated along with the written answers received and will be taken as read as part of an addendum circulated separately at the meeting.

Contact Officer: Mark Wall Tel: 01273 291006

56 ORAL QUESTIONS FROM COUNCILLORS 75 - 78

A list of Councillors who have indicated their desire to ask an oral question at the meeting along with the subject matters has been listed in the agenda papers.

Contact Officer: Mark Wall Tel: 01273 291006

6.30 - 7.00PM REFRESHMENT BREAK

Note: A refreshment break is scheduled for 6.30pm although this may alter slightly depending on how the meeting is proceeding and the view of the Mayor.

REPORTS FOR DECISION

57 CORPORATE PLAN 2020-2023 **79 - 102**

Extract from the proceedings of the Policy & Resources Committee meeting held on the 5 December 2019, together with a report of the Executive Lead Officer for Strategy, Governance & Law.

Contact Officer: *Simon Newell, Steve Morton* *Tel: 01273 291128*
Ward Affected: *All Wards*

58 REVIEW OF THE CONSTITUTION **103 - 140**

Extract from the proceedings of the Policy & Resources Committee meeting held on the 5 December 2019, together with a report of the Executive Lead Officer for Strategy, Governance & Law.

Contact Officer: *Elizabeth Culbert* *Tel: 01273 291515*
Ward Affected: *All Wards*

REPORTS REFERRED FOR INFORMATION

59 SUSSEX HEALTH AND CARE PLAN -THE LOCAL RESPONSE TO THE NHS LONG TERM PLAN **141 - 478**

Extract from the proceedings of the Special meeting of the Health & Wellbeing Board meeting held on the 5 November 2019, together with a Joint report of the Executive Managing Director, Brighton & Hove Clinical Commissioning Group, and the Executive Director for Health & Adult Social Care.

Contact Officer: *Penny Jennings* *Tel: 01273 291065*
Ward Affected: *All Wards*

NOTICES OF MOTION

60 THE FOLLOWING NOTICES OF MOTION HAVE BEEN SUBMITTED BY MEMBERS FOR CONSIDERATION: **479 - 486**

(1) **Moulsecoomb Primary School Sponsor.** Proposed by Councillor Knight on behalf of the Labour Group.

(2) **NHS Health and Social Care Decision Making: Democratic Deficit**. Proposed by Councillor Shanks on behalf of the Green Group.

(3) **'Party Houses' – Short-Term Lets.** Proposed by Councillor Evans on behalf of the Labour Group.

(4) Proportional Representation and Voter Trials. Proposed by Councillor Mac Cafferty on behalf of the Green Group.

61 CLOSE OF MEETING

The Mayor will move a closure motion under Procedure Rule 17 to terminate the meeting 4 hours after the beginning of the meeting (excluding any breaks/adjournments).

Note:

1. *The Mayor will put the motion to the vote and if it is carried will then:-*

   (a) Call on the Member who had moved the item under discussion to give their right of reply, before then putting the matter to the vote, taking into account the need to put any amendments that have been moved to the vote first;

   (b) Each remaining item on the agenda that has not been dealt with will then be taken in the order they appear on the agenda and put to the vote without debate.

   The Member responsible for moving each item will be given the opportunity by the Mayor to withdraw the item or to have it voted on. If there are any amendments that have been submitted, these will be taken and voted on first in the order that they were received.

   (c) Following completion of the outstanding items, the Mayor will then close the meeting.

2. *If the motion moved by the Mayor is **not carried** the meeting will continue in the normal way, with each item being moved and debated and voted on.*

3. *Any Member will still have the opportunity to move a closure motion should they so wish. If such a motion is moved and seconded, then the same procedure as outlined above will be followed.*

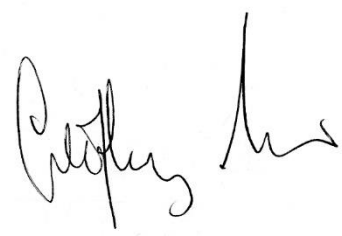
   Once all the remaining items have been dealt with the Mayor will close the meeting.

FOR INFORMATION

Listed below are responses from Government Departments and other Bodies which have been written to by the Chief Executive following the approval of Notices of Motions at previous council meetings:

(1) Sustainable Adult Social Care Funding – Letter from Rt. Hon. Robert Jenrick MP, Secretary of State for Housing, Communities & Local Government.

Date of Publication - Wednesday, 11 December 2019



Chief Executive
Hove Town Hall
Norton Road
Hove
BN3 3BQ

PUBLIC INVOLVEMENT
The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

The closing date for receipt of public questions and deputations for the next meeting is 12 noon on the fourth working day before the meeting.

WEBCASTING NOTICE
This meeting may be filmed for live or subsequent broadcast via the Council's website. At the start of the meeting the Chair will confirm if all or part of the meeting is being filmed. You should be aware that the Council is a Data Controller under the Data Protection Act 1998. Data collected during this web cast will be retained in accordance with the Council's published policy.

Therefore, by entering the meeting room and using the seats in the chamber you are deemed to be consenting to being filmed and to the possible use of those images and sound recordings for the purpose of web casting and/or Member training. If members of the public do not wish to have their image captured, they should sit in the public gallery area.

If you have any queries regarding this, please contact the Head of Democratic Services or the designated Democratic Services Officer listed on the agenda.

ACCESS NOTICE
The Public Gallery is situated on the first floor of the Town Hall and is limited in size but does have 2 spaces designated for wheelchair users. There is an accessible lift to the first floor and ramped access to the public gallery. However, the lift cannot be used as part of a manged evacuation and therefore anyone unable to use the stairs or transfer to an evac chair should not use the pubic gallery but seek assistance from reception.

We have made a number of adjustments to make the venue as accessible as possible and the seated spaces available in the public gallery can be used by disabled people who are not wheelchair users.

Infra-red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.

If you wish to attend a meeting but are unable to use stairs please contact the Democratic Services Team (Tel: 01273 291066 or Email: democratic.services@brighton-hove.gov.uk) in advance of the meeting to discuss your access requirements. We can then work with you to enable your attendance and also to ensure your safe evacuation from the building in the event of an emergency.

If the public gallery is full, Room G87 on the ground floor can be used as an inclusive space with video conferencing facilities and AV links to the council chamber, level access, and nearby WC facilities, including wheelchair accessible provision. From this room you can watch the meeting and take part in proceedings, for example if you have submitted a public question.

FIRE / EMERGENCY EVACUATION PROCEDURE

If the fire alarm sounds continuously, or if you are instructed to do so, you must leave the building by the nearest available exit. You will be directed to the nearest exit by council staff. It is vital that you follow their instructions:

- You should proceed calmly; do not run and do not use the lifts;
- Do not stop to collect personal belongings;
- Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and
- Do not re-enter the building until told that it is safe to do so.

FURTHER INFORMATION

For further details and general enquiries about this meeting contact Mark Wall, (01273 291006, email mark.wall@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

BRIGHTON & HOVE CITY COUNCIL

COUNCIL

4.30pm 24 OCTOBER 2019

HOVE TOWN HALL, COUNCIL CHAMBER

MINUTES

Present: Councillors Phillips (Chair), Robins (Deputy Chair), Simson, Allcock, Bagaeen, Barnett, Bell, Brennan, Brown, Childs, Clare, Davis, Deane, Druitt, Ebel, Evans, Fishleigh, Fowler, Gibson, Grimshaw, Hamilton, Heley, Hill, Hills, Hugh-Jones, Janio, Knight, Lewry, Lloyd, Mac Cafferty, Mears, McNair, Miller, Moonan, Nemeth, Nield, O'Quinn, Osborne, Peltzer Dunn, Pissaridou, Platts, Powell, Rainey, Shanks, C Theobald, West, Wilkinson and Williams.

PART ONE

32 DECLARATIONS OF INTEREST

32.1 Councillor Druitt declared a personal and prejudicial interest in Item 45 (3), a Notice of Motion concerning School Transport as he was the General Manager of Brighton & Hove Community Transport which provided services for school transport. As such he would withdraw from the chamber and take no part in the debate or voting on the matter.

32.2 Councillor Simson declared a personal but no prejudicial interest in Items 38 (2) Petition and 45 (6) Notice of Motion concerning safe to school walking as her daughter worked at Hill Park School.

32.3 Councillor Phillips declared a personal but no prejudicial interest in Item 45 (3) Notice of Motion concerning School Transport as her partner was the General Manager of Brighton & Hove Community Transport. She had applied for and been granted dispensation by the Monitoring Officer to remain and take part in the debate but would refrain from voting on the matter.

32.4 No other declarations of interests in matters appearing on the agenda were made.

33 MINUTES

33.1 The minutes of the Special meeting held on the 25th July 2019 were approved and signed by the Mayor as a correct record of the proceedings;

33.2 The minutes of the last ordinary meeting held on the 25th July 2019 were approved and signed by the Mayor as a correct record of the proceedings;

33.3 Councillor Mac Cafferty referred to the minutes of the Extraordinary meeting held on the 3rd October and noted that the Conservative Group Members were listed as being present, but they had not remained for the debate and therefore questioned whether they should be listed as being present.

33.4 The Monitoring Officer stated that the Members in question had signed the attendance register and as such were recorded as having been present, albeit that they did not remain for the discussion of the item in question. There was no requirement for a councillor to remain for the duration of a meeting but having signed the register their attendance had to be taken on face value.

33.5 The Mayor noted the information and asked that the minutes be agreed, which the council approved and she therefore signed them as a correct record of the proceedings.

34 MAYOR'S COMMUNICATIONS.

34.1 The Mayor stated that she wished to offer the Full Council's support and to extend its sympathy and condolences to residents from Pankhurst Avenue, some of whom lost their homes and everything in them and others who have been unable to return home since Friday 20 September when a terrible fire started and took hold in their block of flats. The emotional trauma of seeing that fire and losing your home is utterly incomprehensible to most of us and I urge residents to contact Councillor Williams as the Chair of the Housing Committee or the Hanover & Elm Grove Ward councillors if they needed any support.

34.2 It was her privilege on behalf of the council to welcome those people who were directly involved in dealing with that terrible fire and its immediate aftermath. Their actions were to be rightly recognised and our thanks offered for their unequivocal support to the residents and those affected by the fire. So many people helped in so many different ways. The firefighters who responded so quickly and tackled the fire on that windy night, including crews from across the Service attended including local firefighters from Preston Circus, Roedean and Hove. Officers involved in the incident included Andrew Gausden, Nigel Cusack, Dan Channon, Matt Lloyd and Mark Andrews. The people who opened up the rest centre late that evening and helped people get warm.

The members of the community who started donating food and drink, clothes and furniture and who set up a fundraising page which has donations now of over £10,000 – which as Landlords of the flats the Guinness Partnership has said they will match fund. The support provided by specialists to those people experiencing shock and trauma. The team at the Control Centre took multiple 999 calls and worked hard to ensure the right resources were sent to the scene. West Sussex Fire and Rescue Service also assisted, with crews from Worthing and Burgess Hill and Station Commander Richard Bradley. They were supported by the Service's engineering team and Sasha Phillips from the communications team.

I would also to thank the other blue light services who provided support on the night. There are simply too many endeavours to name each and every one. I would therefore like to ask the Chief Executive to call on the following to come forward so that I can present them with a certificate as a mark of the city's and the council's gratitude for their endeavours. I will also ensure that certificates are given out to those who could not attend and that their names are recorded in the minutes.

34.3 The Mayor then stated that she would like to congratulate Ryan Pook, a Brighton & Hove lifeguard who, in early summer, swam through rough waves and high winds to help rescue a 13-year-old, despite the treacherous conditions at Black Rock he, was able to support and secure the boy in a rescue tube, reassure him and hold him clear of breaking waves.

The seafront team are an essential part of our council services and much valued for the job they do keeping people safe. Could I ask Ryan along with Councillor Robins to come forward to accept a certificate of recognition for his service.

34.4 The Mayor noted that the Royal Pavilion & Museums had won a prestigious Georgian Group award for the best restoration of a Georgian Interior as part of the 2019 Georgian Group Architectural Awards in recognition of the quality of the restoration work undertaken on the Saloon in the Royal Pavilion. Could I ask Janita Bagshawe, David Beevers and Tim Thearle along with Councillor Robins to come forward to accept the certificate.

34.5 The Mayor also noted that the team behind Brighton & Hove's Volks Railway, the oldest working electric railway has won a Public & Community Award from the Sussex Heritage Award In recognition of how the creation of a new visitor centre and station by the Aquarium has vastly improved the railway for residents and visitors attracting more that 400 people an hour at peak times. She then asked Barry Fuller along with Councillor Robins to come forward to accept the award.

34.6 The Mayor then outlined a few of her forthcoming engagements:

(a) A Civic Service would take place at St Nicholas Church in Brighton on the 1 December, all Councillors will have received invitations to attend.

(b) A lecture relating to the newly returned artefact from the Royal Collection to the Royal Pavilion, on loan for a limited time only, takes place on the 5 December in aid of the Mayor's charities. Support from Councillors is appreciated with tickets priced £20, for enquiries please contact the Civic Office.

(c) The Mayor's Christmas Reception Friday the 13 December (Lucia) at Brighton Town Hall, you are in for a real treat with the Actually Gay Men's Choir performing. Everyone is welcome to attend.

35 TO RECEIVE PETITIONS AND E-PETITIONS.

35.1 The Mayor invited the submission of petitions from councillors and members of the public. She reminded the Council that petitions would be referred to the appropriate

decision-making body without debate and the person presenting the petition would be invited to attend the meeting to which the petition was referred.

35.2 Councillor Childs presented a petition on behalf of Mr Mason and signed by 416 residents calling for the pedestrianisation of St James' Street.

35.3 The Mayor noted thanked Councillor Childs and noted that there were no other petitions to be presented.

36 WRITTEN QUESTIONS FROM MEMBERS OF THE PUBLIC.

36.1 The Mayor reported that 5 written questions had been received from members of the public and invited Mr. Nigel Furness to come forward and address the council.

36.2 Mr. Furness asked the following question; Councillor Platts, our current Mayor, Councillor Alex Phillips, also holds office as a Member of the European Parliament and is now proposing to stand as a Prospective Parliamentary Candidate for Brighton Kemp Town. As these latter two categories involve publicly participating in politics, is this a conflict of interest?

36.3 Councillor Platts replied; Thank you, Mr. Furness, for your question. Your question relates to the Mayoralty rather than the policies or actions of the Administration. As such, I do not feel it would be appropriate for me to comment. I would, however, like, with your permission Madam Mayor, to ask the Monitoring Officer if he would be able to explain the legal and constitutional position.

36.4 The Monitoring Officer stated that the Local Government Act 1972 did not prohibit the Mayor from standing as an MP; although they would need to be mindful of the office in regard to their canvassing. The only restriction was that it was not possible to hold both the office of an MEP and MP. Should there be a General Election and the Mayor was elected, she would have to stand-down as an MEP.

36.5 Mr. Furness asked the following supplementary question; would Councillor Platts take on board the legal position and ask the Mayor to relinquish the chains of office as they would be unable to campaign otherwise.

36.6 The Mayor noted the question and asked the Monitoring Officer to respond.

36.7 The Monitoring Officer confirmed that the only restriction was that the office of MEP and MP could not be held at the same time. The role of the Mayor was not affected by a decision to stand for election to Parliament.

36.8 The Mayor thanked Mr. Furness for his questions and invited Mr. Christopher Hawtree to come forward and address the council.

36.9 Mr. Hawtree asked the following question; Would Councillor Robins please tell us when the use of the £121,000 per year (which was brought back to Libraries at February's Budget) will be discussed at a Committee, as promised by Councillor Knight in her reply to my supplementary question several months ago?

36.10 Councillor Robins replied; £63,000 of the £121,000 put back into the Libraries' budget to help safeguard the future of library services has been permanently added to the staffing budget, enabling 60 extra hours a week for frontline staffing across the library service. The remaining £58,000 is being used this year to cover temporary staffing pressures, and to support the setting up of the new Business and IP service, and the development of a new four-year Libraries Service plan. The longer-term use of the remaining £58,000 will be discussed as part of the ongoing budget proposals, due to come to Policy & Resources Committee on 5th December.

36.11 Mr. Hawtree asked the following supplementary question; Could Councillor Robins confirm what the position is regarding the Library Plan and when it was likely to come to committee?

36.12 Councillor Robins replied; The Library Service Plan had been drawn up and was due to be outlined at a workshop on the 19th November which was open to all councillors and he hoped that many would attend to provide feedback.

36.13 The Mayor thanked Mr. Hawtree for his questions and invited Mr. Ollie Sykes to come forward and address the council.

36.14 Mr. Sykes asked the following question; February Budget Council allocated £190k in recurrent funding to the rebuilding of the council's Sustainability Team to help the council better address climate and wildlife emergencies as these concern our city, as well as other matters such as fuel poverty in our city. Can the Chair of ETS please provide an update on the implementation of that agreed allocation?

36.15 Councillor Pissaridou replied; Budget Council on 28 February agreed £190k in new funding to the council's Sustainability Team to provide staff and other resources required to expand activity in climate change mitigation and biodiversity protection and enhancement, following Council's unanimous declaration of climate and biodiversity emergencies in December 2018. This work may include development of citywide initiatives such as food waste collection, district heat installations, renewable energy development, biodiversity enhancement in the urban and rural estate and green infrastructure work.

In 19/20 a smaller amount of the additional will be spent on staffing, and the majority is allocated to sustainability initiatives. Current plans include a minimum £75k allocation to the emerging Carbon Neutral 2030 programme which will help to develop our city response to the Climate Emergency, including supporting the development and delivery of a Citizens Assembly on climate change. In addition, approximately £25k of the funding is being used to develop the Circular Economy route map, which will present opportunities to understand how better use of materials, resources and space can help to significantly reduce our carbon footprint. The route map will focus on two sectors initially: the built environment and construction, and the visitor economy, and it is anticipated that the route map could be approved in spring 2020.

From 20/21 most of the funding will allocated to new sustainability posts and a restructure of the Sustainability team will take place in the coming months. Roles are likely to include an additional Sustainability project manager and a Biodiversity officer. Work is underway to determine the exact structure and role descriptions required in

line with HR policies and procedures, as part of a wider service redesign of teams within City Development & Regeneration. In addition, discussions are underway with other council teams to part fund roles around Energy and green infrastructure – it is envisaged that these roles could be recruited in early 2020.

Any underspend of this £190k allocation in 2019/20, will be spent on alternative sustainability initiatives. This could include revenue elements relating to capital projects funded through the £500k Sustainability and Carbon Reduction Investment Fund (SCRIF).

36.16 Mr. Sykes asked the following supplementary question; whilst we are a Silver Food Standard City, I wondered if the Chair of ETS would considers using some of the funding referred to, to enable the city to achieve the Gold Standard?

36.17 Councillor Pissaridou replied; In 2021 the intention is to allocate the funding to new sustainability posts, but I am more than happy to take on board the request and look at what can be done to enable the council to work towards the Gold Standard.

36.18 The Mayor thanked Mr. Sykes for his questions and invited Mr. Daniel Harris to come forward and address the council.

36.19 Mr. Harris asked the following question; The Valley Social Club has been a staple of the Whitehawk community for generations, starting as a shack and with the help of the local community who helped to fundraise we have the large community building which is standing today. In 2015 over 10 trustees resigned, leaving two and Conservative Councillor Mary Mears left. The building has been inaccessible to the local community. I support the council buying this asset. Can the council confirm the completion date and price paid for the Valley Social Club?

36.20 Councillor Platts replied; The council's Policy & Resources Committee authorised the purchase of the Valley Social Centre at their October meeting in order to secure the site for community facilities and social housing that would benefit the wider Whitehawk community. Negotiations are currently underway with Trustees, but the sale and final price are yet to be agreed. The council is not at liberty to say anymore at this stage.

36.21 Mr. Harris asked the following supplementary question; Would the council halt its Neighbourhood Plan until there have been consultations with the community about the need for a community facility in the area.?

36.22 Councillor Platts replied; There is provision for the community to be consulted in due course, however the objective at present is to secure the site so that its future can then be determined for the benefit of the community.

36.23 The Mayor thanked Mr. Harris for his questions and invited Ms. Irina Blosse to come forward and address the council.

36.24 Ms. Blosse asked the following question; EMF safety limit guidelines were set by The International Commission on Non-Ionizing Radiation Protection (ICNIRP) in 1998. However, because many health effects from radiation below the guidelines' levels were confirmed by scientists and doctors, many countries including France, Cyprus and

Russia chose to significantly reduce these limits, especially in places where children were present: schools, playgrounds etc. Children and pregnant women are the most vulnerable. Shouldn't we be taking extreme care when proposing to increase the radiation levels even further with 5G and adopt a Precautionary Principle instead?

36.25 Councillor Moonan replied; Nationally, Public Health England provides the expert advice on public health matters associated with radiofrequency electromagnetic fields, or radio waves, used in telecommunications. The implementation and regulation of 5G technology is a national responsibility and local authorities do not have a direct role other than considering the installation of new transmitters within the planning process.

Public Health England has provided the following information on the safety of 5G technology. The UK uses international health-related guideline levels that are based on the International Commission on Non-Ionizing Radiation Protection (ICNIRP). Current technical standards that draw on the ICNIRP guidelines will apply to the 5G products that are developed. UK network operators are already committed to complying with the ICNIRP guidelines.

The highest frequencies being discussed for future use by 5G are around 10 times higher than those used by current network technologies, up to a few tens of gigahertz (GHz).

Their use is not new, and they have been used for point-to-point microwave links and some other types of transmitters that have been present in the environment for many years. ICNIRP guidelines apply well beyond the maximum frequencies proposed for 5G.

PHE advise that it is possible that there may be a small increase in overall exposure to radio waves when 5G is added to an existing network or in a new area. However, the overall exposure is expected to remain low relative to guidelines and, as such, there should be no consequences for public health. PHE has stated it is committed to monitoring the evidence applicable to this and other radio technologies, and to revising its advice, should that be necessary.

36.26 Ms. Blosse asked the following supplementary question; The ICNIRP guidelines were set up as a result of research into the heating effects from EMF on an adult brain. It does not take into consideration however that a child's brain, bones and biology are different to that of an adult. The ICNIRP have a disclaimer that they are not responsible for any third-party damage and their guidelines are only for information.

Will Brighton and Hove Council be responsible then for any damage to our children from exposure to EMF from 5G, if they allow this technology to be rolled-out in Brighton and Hove?

36.27 Councillor Moonan replied; I do understand your concerns and anxiety and to reiterate our powers as a local authority are limited and we do not have the scientific expertise and have to rely on Public Health England to give advice. We are following that advice and if it changes out response would change as a result.

36.28 The Mayor thanked Ms. Blosse for her questions and noted that concluded the item.

37 DEPUTATIONS FROM MEMBERS OF THE PUBLIC.

37.1 The Mayor reported that three deputations had been received from members of the public and noted that there was a Notice of Motion listed at Item 45 (3), Home to School Transport – Policy Panel on the agenda which related to the first deputation. She was also aware of an amendment to the notice of motion from the Green Group and would therefore take the motion and the amendment directly after the deputation had been made and responded to.

37.2 The Mayor also noted that some of the people supporting the first deputation had been delayed and therefore invited Mr. Rolfe as the spokesperson for the second deputation to come forward and address the council.

(2) PRIDE PVP

37.3 Mr. Rolfe thanked the Mayor and stated that, On the 19th April 2018 The Kingscliffe Society made a deputation to B&HCC about Health & Safety concerns over the Pride PVP annual event. We were directed to the Tourism Development & Culture Committee and thence to Safer Communities who were to produce a Review in the form of a questionnaire as a public condition. They issued their questionnaire on the day before they surveyed/walked the St James's PVP Area with us (TKS) together with the St James's LAT group. Therefore, none of our issues pointed out during the survey could be included in the B&HCC questionnaire. The results from the questionnaire formed more a Popularity Poll than the Review as promised (which was to cover all residents & business concerns) but were presented as a factual outcome dealing full with all the issues raised.

We have, therefore, continued to pursue our H&S concerns and requirements at Council meetings and by emails, but all to no avail.

In the Agreement the B&HCC made with the Pride organisation in 2014 various clauses were included to improve the management of this event, specifically;

3.15 with the explicit intentions of creating a safer and welcoming event.
3.16 *PVP format aimed at creating an event that achieves a better outcome/or attendees, businesses and local residents (our underlines)*
3.19 Evaluation of the PVP by the Safety Advisory Group (including the councils emergency services) with regard to the event's objectives of delivering a safer and high-quality event was largely very positive. The evaluation process with local businesses and communities is ongoing at the time of report writing and any further information will be provided at meetings.

We dispute whether these objectives have ever been fully achieved.
In regard to 3.15. As the PVP does not commence until 6pm, many attendees arrive for the event already intoxicated or drug affected from the 'Party in the Park' where they have been indulging all afternoon.
In regard to 3.16. As the PVP has an overwhelming emphasis on over-loud music (up to 120 DPC inside homes) and the on-street alcohol consumption promoted by

the demands of St James's abundant licensed premises. The wishes of residents & unlicensed traders are therefore given very low priority.
In regard to 3.19 During the last 2 years in St James St. Pride has estimated an attendance@ between 35,000 & 42,000 revellers in its narrow adjacent side streets, filled to overflowing with somewhat intoxicated revellers contained behind un-climbable barriers. With no public address system, emergency lighting, and escape signage and no pre-issued escape plan for residents or revellers to follow. The 2-meter-high non-climb barricades are erected from midday on the Friday until late night on the Sunday and for the last 2 years of PVP event and no pre or post PVP meetings have been organized so no relevant information is exchanged and acted upon.
It is recognised that the PVP is raising funds, one aspect of which is a social fund to reduce the effect it has on the wider community, but it is raised by imposing unreasonable distress and conditions on many local residents and non-licensed traders who are bearing the brunt of the true cost.
Any emergency is a tragedy waiting to happen.
With respect, we would ask the Council to withdraw the Pride PVP agreement and employ a Company that will comply with the Council's Requirements & those of Health and Safety.

37.4 Councillor Robins stated that he had a full response for the deputation and suggested that it be recorded in the minutes and sent to Mr. Scoble, but in the meantime wished to thank Mr. Rolfe for presenting the deputation.

Note: the full response is detailed below:

A review of the Pride Village Party was carried out in 2018 following a previous deputation from the Kingscliffe Society. Part of that review was a public consultation about the event continuing in the location of St James' St. Nearly 3000 responses were received with support largely in favour of the event continuing to be held in the St James' St area, many of those responses were from local residents and businesses and again there was a majority of support from those responding that it should remain where it is. The consultation was only part of that review, evidence was included in the committee report about complaints received about the event especially about noise and the report showed that there were very few, and also the event site plan which showed points of egress and ingress and the routes for emergency vehicle access.

The points that have been raised by the Kingscliffe Society about the Health and Safety arrangements were discussed at two independent safety advisory groups in July 2019 and it was felt by the group, made up of senior officers from the Council and emergency services that the risk assessments carried out by Pride Community Interest Company mitigated the risks and were compliant with current Health and Safety guidelines.

Public address systems can be taken over and used to make announcements. An exercise took place looking at evacuation following guidance around Safety in Public Places. 82,000 people can be evacuated from the area in under 10 minutes should the need arise. Every Road has security and stewards, in the event of an emergency the music systems / and security will be on hand to advise people to stay indoors or not depending on the situation.

During the run up to the event and after the event there are regular meetings to ensure that all mitigation to manage risks are in place and that any lessons learnt from the previous year are incorporated into the planning process for the following year. Pride CIC works with the statutory agencies throughout this to ensure that they put in place recommendations from the statutory agencies such as the police, fire service and the health and safety officers at the council. A detailed event management plan is produced and again this will be amended in light of recommendations from the safety advisory group and others.

During the event Pride are based in Dorset Gardens throughout the weekend, with regular Event liaison team meetings which are fed back to a multiagency Silver command and there is ongoing communication for the duration of the live event, over the whole weekend.

Pride hold regular meetings with residents in the run up to the event and officers are on site to check noise levels during the event and to ensure the safety of both residents and party goers.

We are satisfied that there are contingencies in place for the event to continue to be run by Pride CIC for 2020.

37.5 The Mayor thanked Mr. Rolfe for attending the meeting and speaking on behalf of the deputation. She explained that the points had been noted and the deputation would be referred to the Tourism, Equalities, Communities & Culture Committee for consideration. The persons forming the deputation would be invited to attend the meeting and would be informed subsequently of any action to be taken or proposed in relation to the matter set out in the deputation.

(1) HOME TO SCHOOL TRANSPORT FOR STUDENTS WITH SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND)

37.6 The Mayor then invited Ms. Pippa Hodge as the spokesperson for the first deputation to come forward and address the council.

37.7 Ms. Hodge thanked the Mayor and stated that, Children as young as 4 or 5 years old, rely on this Service to take them safely to/from the setting named in their Education, Health & Care Plan (EHCP) in line with Statutory Duties* (Appendix 2). Numbers are rising year on year. The previous 4-year Contractor Framework expired in August 2019. Several years of Contractor consistency created effective links between Schools/Colleges, Parent Carers (& their CYP) and the local Brighton Contractors (Community Transport take many of the children using wheelchairs, some with profound and multiple learning disabilities). Whilst not without glitches, the long-standing system centred around acquired SEND/Autism training & awareness, plus familiarity with pupils individually, which built trust and delivered a reliable service. Crucially:

Each child was recognised as an individual with discreet Core Support Needs, e.g. living between 2 parents' homes, or being a child who regularly went to Respite (their Care package), or specialist clubs, to enhance Life Skills. This essential community

cohesion was recognised as a fundamental factor in 'Whole Child' Wellness and Development, upholding Equalities and City CYP Key Principles

Drivers and Escorts, supported by back offices, used their common sense and route knowledge to minimise the stress for children, ensure that they arrived on time and ready to learn, and to enable working parents to meet their obligations, or get other young children to school.

When possible, Drivers and Escorts remained with their cohort of children, building up trust and assisting that difficult transition between home/school/home which many youngsters with SEND, especially those with Autism &/or Sensory Processing Difficulties, typically find overwhelming.

In March 2019, a Dynamic Purchasing System/DPS (a bid-down system) to reduce Overspend was proposed by Edge Public Solutions (employed as Advisors in January 2019). A DPS approach had been discussed at Policy, Resource & Growth Committee (11/10/18*). Meeting minutes (Conclusion 7.2) authorised a new framework, but not a DPS (since the simulated desktop exercise did not prove the anticipated savings to the Committee's satisfaction). Nevertheless, a DPS was approved, via Urgency Powers (March 2019) without passing back through PRG or CYP Committees. As a direct result of these changes the transport scheme is failing to safeguard our children.

We Request A Full Cross-Party Scrutiny Group So This Never Happens Again. We ask Councillors from each party to fulfil your Responsibilities and personally conduct a beginning to end scrutiny of events, in keeping with your stated civic duties as elected councillors.

We challenge the logic & validity of the Independent Review: this was again presented as a 'fait accompli'; 'Officers investigating Officers' cannot be 'independent' (every LA is facing Transport issues); Parent Carers do not want to speak with yet more Officers from another Authority when they struggle with their own; Officers will leave once their report is submitted, and there will be no accountability for changes or a safe framework legacy. You are our Councillors & Moral Guardians of Civic Services. Please, put our City's Children above local Politics. We must learn how this has gone so shockingly wrong. No more personal cost to our children's physical safety, mental wellbeing and education; or to families; no more 'wait and see if there are incidents'; no more financial cost of outsourcing to '3rd parties' from our City Budget. Councillors, we are beyond apologies, please act.

37.8 Councillor Allcock replied, Thank you for your passionate and heartfelt deputation Pippa. Obviously, we have been in contact before today in person and by email, but I am glad to have your direct input at this meeting, as I am sure all elected members are.

I hope you are able to accept that there has been full recognition of the problems that some parents faced at the start of this term and I know that for some this is still ongoing. Arrangements certainly did not proceed as planned. This should not have happened, and no one wants this to happen again. I want to repeat this unreserved apology today. But I also want to reassure you and all parents and carers that we will not rest until this situation is completely resolved.

I understand we urgently need to re-build trust between the community and the local authority and therefore, as an Administration, we believe it is important that a review is carried out. A review that will be fully independent of the Council which will be asked to investigate all areas of the home to school transport function, including the initial decision-making process to change the arrangements. Lead reviewers have already been identified and a decision on this will be made by me in consultation with the Chair of the Audit & Standards Committee and PACC. In addition, following a suggestion from PACC, the review will be supported by a representative from Contact – a national charity working with the families of disabled children who will also get in touch with families directly. Contact is not a Local Authority service and is not staffed by council officers. We are also considering other ways to enable greater levels of parent/carer oversight of the review.

We want a level of scrutiny and challenge to make sure that we learn all there is to learn from this and so we can use that knowledge to make improvements. We know this will not be comfortable, but it needs to be done and done quickly so that any improvements can be implemented as soon as they are identified. The final draft of the terms of reference for the Independent Review have now been agreed which, again, incorporates valuable input from the Parent and Carer Council as well as the suggestions of the Chair of the Audit & Standards Committee. At our request these are drawn as widely as possible. As Chair of this committee I promise you that I want every aspect looked at and when I say no stone unturned I mean it.

Representative groups, many of them here today, as well as individual families affected must and will have the opportunity to share their views and experiences with the reviewers, as part of their work. I know that you, and others are asking for an internal, cross-party Member led Policy Panel, and we are more than happy to work with Members to provide this additional layer of scrutiny. But our first priority has always been to resolve the problems our young people and their families have faced, with the scrutiny and review now running alongside. Having an independent outsider working on this as well will, we hope, encourage greater openness and transparency.

Of course, we completely understand why other elected Members want answers to questions and a degree of oversight themselves. So, as well as encouraging councillors across the spectrum to engage with, and contribute to, the Member-led panel and the Independent Review, I have agreed that there could be a that a short report to provide a progress update on the independent review and the current situation with Home to school transport brought to the next meeting of the Children Young People & Skills Committee in November. Members will have an opportunity there to ask questions about the review.

Once the Independent Review is completed as planned, it is anticipated that a further, final report will be brought to the January meeting of the CYPS committee. The committee system in Brighton & Hove is designed to give opportunities for councillors to both set policy at committees and also to scrutinise the work of the council. I expect and hope that councillors will want to ask questions about any recommendations coming from the review and also to be assured that actions are in place to address these recommendations. Future meetings of the CYPS committee and reports from the policy panel will provide robust opportunities to scrutinise progress.

By its definition, an Independent Review ensures that all areas of the council's work can be explored as part of the review without any party-political influence getting in the way of the changes that I'm sure families in the city would want for the future. If the CYPS committee or the Policy Panel continues to have concerns, then these can also be referred to a future meeting of Full Council. It is vital therefore that we learn from what went wrong and make changes for the future.

45. **NOTICES OF MOTION**

(3) HOME TO SCHOOL TRANSPORT – POLICY PANEL

37.9 The Mayor then invited Councillor Mears to move the Notice of Motion, Item 45 (3) on the agenda.

37.10 Councillor Mears thanked the Mayor and Ms. Hodge for bringing her deputation to the meeting. She stated that all Members had a responsibility as corporate parents and to ensure that the home to school transport service met the needs of the children concerned. She acknowledged that all new contracts experienced teething troubles, but it was clear this contract was not fit for purpose. Members had raised questions at the committee and expressed concern over the lack of Member oversight for the contract. Hence the motion called for a cross-party Member Panel to review the process of issuing the contract and to feed into the Independent Review. She also confirmed that she was happy to accept the Green Group's amendment.

37.11 Councillor Simson formally seconded the motion and reserved her right to speak in the debate.

37.12 Councillor Clare stated that she wished to thank the parents and children for attending today's meeting and that she believed the changes to the contract had led to an unacceptable level of distress for them. She welcomed the proposal for an Independent Review but agreed that there was a need to begin reviewing the process as soon as possible and therefore the amendment sought to add to the notice of motion.

37.13 Councillor Hugh-Jones formally seconded the amendment.

37.14 Councillor Knight stated that no-one had wanted to be in the position that currently existed and fully supported the apology given by Councillor Allcock. However, there was a need to move forward and take action and to understand the decision-making process so that improvements could be made. She welcomed the cross-party panel as it would enable Members to review matters and provide transparency and accountability. She hoped that all councillors would work together to resolve the difficulties and to regain the trust of parents and the young people.

37.15 Councillor Bell expressed his concern over how the situation had been reached and his frustration that having raised questions previously at committee these had not been addressed. He believed it was appropriate to have a cross-party Member Panel and hoped that it could begin its review as soon as possible.

37.16 Councillor Simson noted that the value of the contract had meant it fell below the threshold for a report to have to come to committee, however she felt for such an important matter, Members should have had oversight. She questioned whether the Independent Review would be fully independent given that the decision to award the contract was taken under delegated powers. She fully supported the need for a cross-party Member Panel and hoped that lessons could be learnt in regard to the process of awarding the contract and a solution found to the current problems with the contract.

37.17 Councillor Mears noted the comments and stated that it was important for Members to be involved in the review process and the cross-party Member Panel would enable that. She hoped it would then be able to feed into the Independent Review and that all parties concerned would have the opportunity to input into the review process.

37.18 The Mayor thanked Ms. Hodge for attending the meeting and speaking on behalf of the deputation. She explained that the points had been noted and the deputation would be referred to the Children, Young People & Skills Committee for consideration. The persons forming the deputation would be invited to attend the meeting and would be informed subsequently of any action to be taken or proposed in relation to the matter set out in the deputation.

37.19 The Mayor then noted that the amendment to the Notice of Motion had been accepted and therefore put the following motion as amended to the vote:

This council resolves to ask the Children, Families & Skills Committee to urgently establish a cross-party Member led Policy Panel consisting of six Members, two from each political party, and chaired by a Member of the Opposition. It would have the remit to, inter alia, review and discuss solutions to resolving the current negative impact on schools, families, children and young people and generally the implementation of the home to school transport service; and oversee any results of the external investigation proposed by the Administration.

37.20 The Mayor confirmed that the motion had been carried unanimously.

(3) VALLEY GARDENS

37.21 The Mayor then invited Ms. Serena Burt as the spokesperson for the third deputation to come forward and address the council. She also stated that as Item 45 (4) Notice of Motion on Valley Gardens listed on the agenda referred to the same matter, she intended to take the motion immediately after the deputation had been presented and responded to.

37.22 Ms. Burt thanked the Mayor and stated that, I'm here today to briefly talk you through an alternative plan for Valley Gardens phase 3. This has been drawn up by leading architects, engineers and design professionals from our city - on behalf of us all.

The plan is based on the best elements of the Council's own original design options. We don't consider it definitive and so further input is invited and welcomed. Our current version removes most of the transport disbenefits from the current council scheme, provides a much better **cost** benefit ratio with significantly closer alignment to Transport for the South East's stated strategy. It would achieve a more positive

outcome on almost every measure than the current official one - identified as offering 'low value for money' by the Local Enterprise Partnership Coast 2 Capital.

Our core proposition achieves the following:

- The creation of city-wide routes to the centre for cyclists and pedestrians complete with better access to attractive new green spaces increasing biodiversity.
- The creation of a dedicated two-way bus and taxi lane to link North Street to a contiguous public transport corridor at Marlborough Place and retaining the city centre's natural transport hub complete with the three iconic "deco" bus shelters.
- The creation of a 'mixed use' pedestrianised seafront gateway to explore the east of the city Instead of separating Kemptown from the centre with the current proposed scheme.
- The creation of a dedicated cycle hub at Pool Valley with a crossing to the seafront, safely clear of pedestrians at the front of the Pier as well as public transport and general traffic.
- Moving cycle lane away from the Steine gardens perimeter makes access better for the public realm and essential for use as event space.
- The creation of a remodelled roundabout to ensure the safest and most environmentally friendly free movement of general traffic - and removing the need to redevelop the junction at Duke's Mound.

Residents, businesses and public sector professionals across all sectors of the local economy have already offered valuable input. We genuinely believe that something close to this plan is one that the entire city can get behind.

We therefore respectfully ask Full Council to note our proposal and ask the ETS Committee to give full and proper consideration to this plan.

37.23 Councillor Pissaridou replied, thank you for bringing this deputation to Full Council this afternoon. I can see that you are representing a number of businesses and organisations today on behalf of the Valley Gardens Forum.

The deputation serves to underline that there is still a considerable amount of interest in this final phase of the Valley Gardens project, and that there is agreement that investment is urgently needed to assist in regenerating this city centre area. The benefits of doing so will also be felt in areas that are adjacent to it, such as St James's Street and The Lanes.

Although it has been in the media, what I am pleased to be able to say personally today, is that the Local Enterprise Partnership (which is known as the LEP) completed its review and consideration of our Business Case earlier this month. In doing so, it has also taken into account a number of representations that it has received from various sources. The conclusion is that the LEP has finally approved the £6 million pounds worth of external funding for the project. That is a significant milestone for the city and the council, and everyone who has been involved so far.

Once we have entered into the Funding agreement with the LEP, the next stage will be to progress the development of the preferred design that was agreed by the council's Environment, Transport & Sustainability Committee over 8 months ago in February.

This will involve the appointment of a new project team and carrying out further engagement with local people and communities, including the Valley Gardens Forum. Plus, the new Councillor Task & Finish Group that we have agreed to set up for Valley Gardens will have oversight of the next stages for Phase 3 and will include stakeholders in its meetings and discussions.

As an Administration, we are committed to implementing changes that will bring the biggest overall benefits to the most people. That does mean moving away from car usage in the city centre to improve air quality and reduce congestion; it does mean creating more green space to protect the local environment; and it does mean creating more public space to enhance the landmarks that draw people to the city, including the Royal Pavilion and the seafront.

This final phase of the Valley Gardens project will form a vital part of our move to become a carbon-neutral city by 2030 through investment in a safe, accessible, sustainable and high-quality transport network that supports walking, cycling, and public transport. It will also give public space back to the local community, allowing the city's residents and visitors the opportunity to enjoy this area of our city once more.

What I am sure you are aware of, and must emphasise again today, is that the decision made in February was arrived at following considerable debate and discussion by councillors at many council meetings. That debate, and discussion has been informed by thorough public consultation, and heavy scrutiny and challenge. Therefore, the design that has been agreed by the council will be the starting point for the next stage of design, and the final design will need to take into account the budget, time and resources that we have available to complete it.

Undoubtedly, things will change as the design is worked on, but we must remain true to the overall vision for the area and the core objectives that the council has agreed. If we are serious about addressing climate change, improving air quality and future-proofing the city for the years to come, then we must be bold in our vision and we must act now.

I have noted that the proposed option that you have put forward in the deputation includes a considerable number of changes to the agreed design, including: -

- a roundabout at the Palace Pier;
- two extra traffic signal junctions near the Royal Pavilion;
- significant changes to Pool Valley;
- a new crossing on the A259.

Whilst I acknowledge your claims within the deputation, the implications of some of these changes do not appear to have been technically assessed or fully quantified, but we will consider whether any of the ideas put forward can help further support the improvements within the agreed design, while maintaining value for money.

I do recognise that this deputation will be discussed and considered further at the Environment, Transport & Sustainability Committee next month, but thank you again for presenting it today. I hope that my response has helped to explain the point that we have now reached, and how we intend to move forward with this exciting project.

45. NOTICES OF MOTION

(4) VALLEY GARDENS

37.24 The Mayor then invited Councillor Miller to move the Notice of Motion on behalf of the Conservative Group.

37.25 Councillor Miller stated that the need for the redevelopment of Valley Gardens was recognised however, the current scheme was flawed, and he believed would be a waste of public money. The funding from the LEP was welcome but he felt that further consultation was needed to resolve the traffic issue as well as a full environmental impact assessment (EIA). There had been a lack of consultation with the residents affected and he believed the process should be put on hold until other options could be considered.

37.26 Councillor Nemeth formally seconded the motion and stated that plans had been drawn up behind closed doors and there was a need for public involvement. The Valley Gardens Forum had raised a number of valid points and they knew what they were talking about, but their concerns had not been taken into consideration. He supported the need to pause the process and take the opportunity to improve the eco credentials of the project.

37.27 Councillor Bell stated that the scheme had been railroaded through with concerns raised by businesses, communities and residents ignored and a lack of consultation. There was a need for a joined-up scheme that was supported collectively by all affected and hoped this could be achieved.

37.28 Councillor Fishleigh stated that there was a need for an environmental impact assessment and a new transport infrastructure to take account of the Town & Country Planning regulations. She believed there was a need to look beyond party politics, in order to be able to agree a viable scheme that would benefit the city. She also asked for a recorded vote on the motion and hoped this request would be supported.

37.29 The Mayor noted that it was Councillor Fishleigh's maiden speech and congratulated her on behalf of the council.

37.30 Councillor West stated that it had taken time, but the project's completion was in sight and would provide better facilities for everyone in the city. There would be an opportunity to comment on the final design stage and the Member Stakeholder Working Group was due to reconvene which would enable a broader conversation on the proposals. He reminded the council of the objective for the city to be carbon neutral by 2020 and hoped that councillors would support the scheme going forward.

37.31 Councillor Pissaridou stated that she understood the concerns raised in relation to the EIA but noted that the new scheme had been assessed and there was no requirement for a full EIA. However, the situation would continue to be reviewed during the development of the Scheme and design process. There would be further consultation and the configuration of traffic signals and movement of traffic taken into account as part of any engagement during Phase 3.

37.32 Councillor Peltzer Dunn noted the comments and queried if the actions being referred to in the motion were being taken into consideration as part of the process, why then the Notice of Motion could not be supported.

37.33 Councillor Robins stated that he believed the matter had been through various stages at committee and noted that a previous Opposition Spokesperson had championed the Scheme and therefore questioned the opposition to it.

37.34 Councillor Miller stated that the current Scheme was not right for Valley Gardens and cost benefit ratio was questionable. There was a clear need for further consultation and to take on board the views of the local community, local businesses and the residents deserved more. He hoped that the motion would be supported.

37.35 The Mayor thanked Ms. Burt for attending the meeting and speaking on behalf of the deputation. She explained that the points had been noted and the deputation would be referred to the Environment, Transport & Sustainability Committee for consideration. The persons forming the deputation would be invited to attend the meeting and would be informed subsequently of any action to be taken or proposed in relation to the matter set out in the deputation.

37.36 The Mayor noted that Councillor Fishleigh had requested a recorded vote and sought the support of the Council to the request which was confirmed. She therefore asked for a recorded vote to be undertaken on the following motion:

This council requests the Environment, Transport & Sustainability Committee to:

(1) Ensure that Valley Gardens Phase 3 is subject to a full environmental impact assessment; and

(2) That the Duke's Mound junction proposal will be subject to a full public consultation in the context that it not only impacts Valley Gardens Phase 3 but also impacts on the A259 coastal road and the Waterfront/Blackrock development.

37.37 The Head of Democratic Services undertook a recorded vote, the results of which are detailed below:

		For	Against	Abstain			For	Against	Abstain
1	**Allcock**		√		28	**Lewry**	x		
2	~~**Appich**~~	Not Present			29	~~**Littman**~~	Not present		
3	~~**Atkinson**~~	Not present			30	**Lloyd**		√	
4	**Bagaeen**	x			31	**MacCafferty**		√	
5	**Barnett**	x			32	**Mcnair**	x		
6	**Bell**	x			33	**Mears**	x		
7	**Brennan**		√		34	**Miller**	x		

8	**Brown**	x			35	**Moonan**		√	
9	**Childs**		√		36	**Nemeth**	x		
10	**Clare**		√		37	**Nield**		√	
11	**Davis**		√		38	**O'Quinn**		√	
12	**Deane**		√		39	**Osborne**		√	
13	**Druitt**			Ab	40	**Peltzer Dunn**	x		
14	**Gibson**		√		41	**Phillips**			Ab
15	**Grimshaw**		√		42	**Pissaridou**		√	
16	**Ebel**		√		43	**Powell**		√	
17	**Evans**		√		44	**Platts**		√	
18	**Fishleigh**	x			45	**Rainey**		√	
19	**Fowler**		√		46	**Robins**		√	
20	**Hamilton**		√		47	**Shanks**		√	
21	**Heley**		√		48	**Simson**	x		
22	**Henry**	Not present			49	**Theobald C**	x		
23	**Hill**		√		50	~~**Wares**~~	Not present		
24	**Hills**		√		51	**Wilkinson**		√	
25	**Hugh-Jones**		√		52	**Williams**		√	
26	**Janio**	x			53	**West**		√	
27	**Knight**		√		54	**Yates**	Not present		
							14	32	2

37.38 The Mayor confirmed that the motion was lost by 14 votes to 32 with 2 abstentions.

38 PETITIONS FOR COUNCIL DEBATE

38.1 The Mayor stated that where a petition secured 1,250 or more signatures it could be debated at the council meeting. She had been made aware of two such petitions and noted that there was an amendment to the cover report's recommendation for the first petition from the Green Group. The Mayor also noted that there was a Notice of Motion listed as Item 45 (6) Safe School Walking Zones on the agenda and stated that she was minded to take the motion along with the second petition and to have one debate on the matter.

38.2 The Mayor then invited Ms. Gillian Foote to present the petition on 5G technology.

38.3 Ms. Foote thanked the Mayor and stated that the petition which had been signed by 2,240 people called on the Council to halt the rollout of 5G technology in Brighton & Hove and invoke the Precautionary Principal adopted by the EU in 2005 which stated:

"When human activities may lead to morally unacceptable harm that is scientifically plausible but uncertain, actions shall be taken to avoid or diminish that harm."

She stated that the residents of Brighton & Hove, insisted that the City Council should invoke the Precautionary Principal regarding 5G technology and all associated infrastructure before deploying it in our city. We (the residents) now call for independent research and for the City Council to prove to its constituents that 5G is SAFE and poses NO risk to human health, animals, wildlife, insects, birds and the ecosystem as a whole. Once 5G is deployed fully, it will expose people 24/7 to mandatory radiation without their informed consent, which constitutes a blatant breach of their Human Rights.

38.4 Councillor Moonan thanked Ms. Foote for presenting the petition and stated that she hoped she could give her and the petitioners some reassurance. Public Health England (PHE) took the lead nationally and provided expert advice on public health matters associated with mobile phone technology. We have liaised with PHE to get the latest information and guidance and to seek their advice on whether there are any health risks for the public. PHE have told us that the current exposure of the general public to radio waves is well within the international health-related guideline levels that are used in the UK. They said that when 5G is added to an existing network or in a new area the overall exposure to radio waves is expected to remain low relative to these guidelines. As such there should be no consequences for public health.

5G is now being rolled out across the country and UK network operators implementing 5G are committed to complying with the current guidelines. The ability of councils to influence the roll-out of mobile technology is limited by central government regulations and we are unable to adopt a policy to halt the roll out of 5G. But the planning system does require that any new installations are consistent with the international guidelines PHE adheres to.

The council has a vital role to play in encouraging economic development in the city, and digital connectivity is a key part of this. It's particularly important as our local economy has such a strong specialism in the creative, digital and IT sectors. We're keen to promote the most up-to-date and effective mobile and wireless technology for work premises in the city. Our residents also expect this in their homes and on their phones.

Councillor Moonan also stated that she was happy to accept the amendment from the Green Group.

38.5 Councillor Osborne moved the amendment on behalf of the Green Group and stated that it was felt that more information was required so that councillors understood the situation and hoped that it could be supported.

38.6 Councillor Powell formally seconded the amendment and reserved her right to speak in the debate.

38.7 Councillor Bagaeen stated that the matter was an interesting topic and raised important concerns which he had raised with the Director of Public Health England and had been assured that there was no evidence of a danger to health. They maintained precautionary advice on the limited information they had and he suggested that more should be done to get the involvement of mobile operators.

38.8 The Mayor noted that was Councillor Bagaeen's maiden speech and congratulated him on behalf of the council.

38.9 Councillor Powell noted the comments and sated she had nothing to add.

38.10 Councillor Moonan thanked everyone for their comments and sated that she would be happy to explore the matter further at the meeting of the Health & Wellbeing Board.

38.11 The Mayor thanked Ms. Foote for attending the meeting and presenting the petition and noted that the amendment had been accepted. She therefore put the recommendation as amended to the vote which was carried unanimously.

38.12 **RESOLVED:** That the petition be noted and a report on the issue provided for consideration at the next available meeting of Health & Wellbeing Board.

38.13 The Mayor then invited Councillor Nield to present the petition relating to the ability for children to walk safely to schools in the city. The Mayor also noted that there was a Notice of Motion listed as item No. 45 (6) on the agenda which related to the same matter and stated that she therefore intended to take that item at the same time and to have one debate on the issue.

38.14 Councillor Nield thanked the Mayor and stated that she also had a notice of motion on the subject and therefore simply wished to point out that the petition had secured over 1,300 signatures in only a few weeks. It highlighted the concerns that parents/carers had in regard to their children being able to walk safely to school and called for action to be taken to address their concerns.

38.15 Councillor Allcock thanked Councillor Nield for bringing the petition to the council and congratulated her on the campaign. He stated that the council was fully committed to enabling and encouraging children to walk to and from school safely. He noted that a significant number of initiatives and improvements were underway to assist in achieving this aim with a number of schools having already benefitted. The Safer Routes to School programme had been successful and would continue to create an environment in which children felt safe to walk to school.

38.16 The Mayor then invited Councillor Nield to move the Notice of Motion listed as Item No. 45 (6) Safe School Walking Zones.

38.17 Councillor Nield thanked the Mayor and stated that October was the international walk to school month, which promoted the best travel option for children to get to school. She was aware that schools across the city and the country promoted walk to school week and the motion sought to extend that common aim to ensure that children could walk safely to school throughout their school life. At present parents and carers faced

the daily struggle of tackling rush-hour traffic and a lack of safe crossing zones to get their children to school. It meant children were also being denied the opportunity to develop an independence and get to and from school by themselves. There was a need to listen to the concerns of parents and to find solutions to the problems faced on a daily basis and to empower them to take advantage of being able to walk safely to school.

38.18 The Mayor noted that it was Councillor Nield's maiden speech and congratulated her on behalf of the council.

38.19 Councillor Shanks formally seconded the motion and stated that there was a clear need to tackle the issue highlighted by the motion and the petition. She acknowledged that there was a need to change behaviour of parents who opted to drive their children to school as well as other drivers and to reduce traffic levels and hoped that a positive outcome could be found.

38.20 Councillor Moonan welcomed the petition and notice of motion and noted that Public Health England had recently published figures for the health profile of Year 6 and noted that Brighton & Hove compared well with the national figure. However, there was a need to do more and to get young people walking to school and to set habits that would benefit them in later life.

38.21 Councillor Brown welcomed the petition and stated that it highlighted the problem that needed to be addressed. Whilst most schools had travel plans there were still significant hazards that had to be faced and she hoped that the council would work closely with schools and parents to find solutions and then enable them to be implemented. There was a need to be proactive rather than reactive and not to rely on statistics before addressing calls for crossings to be installed. She also noted that funding had been identified at the last Budget Council to help to tackle the issue but had not been approved.

38.22 Councillor O'Quinn noted that 20mph zones had been established in the city and suggested that more signage and consideration of 10mph zones around schools should be considered; as well as action to improve sight lines and to prevent illegal parking around schools. She also suggested that another aspect that should be reviewed was that children were not necessarily local to their school, which meant that parents were choosing to drop them off by car. It was a complex issue and would need to be given full consideration if it was to be addressed.

38.23 Councillor Hill stated that there were issues with major junctions being near to or in between schools which caused difficulties for parents and children. It meant there was a need to prioritise when putting solutions into place and she questioned whether it was possible to re-look at the use of school crossing patrol officers and to encourage people to volunteer.

38.24 Councillor West stated that it was an important matter that needed to be considered and different solutions found for different areas but with the aim of providing safer to school routes. He was aware of school crossing patrol officers being threatened by drivers for stopping the traffic and that had to be addressed. The use of the car to take

children to school should be the exception rather than the norm and children should be given the confidence to be able to walk to school.

38.25 Councillor Bagaeen stated that more action was needed to enforce double yellow lines and to get the bus company to improve the quality of buses being used for the school services. Having experienced travelling by bus himself, he could not allow his children to use the current vehicles that were operating as they were over-crowded, and windows could not be opened. He hoped that discussions could be held with the bus companies to improve their fleet and the number of buses operating on school routes.

38.26 Councillor Nield thanked everyone for their contributions to the debate and stated she was aware of existing schemes to help children to walk to school. However, they tended to concentrate on how to deal with traffic etc. rather than creating safe walking zones and initiatives such as 'School Streets' created in other cities should be considered; as well as establishing a network of zones across the city. She also questioned the reliance on accident data to determine whether a crossing could be provided and the struggle to obtain Section 106 funding and hoped that this could be reviewed.

38.27 The Mayor thanked Councillor Nield for presenting the petition and put the recommendation listed in the covering report to the vote which was carried unanimously.

38.28 **RESOLVED:** That the petition be noted and referred to the Children, Young People & Skills Committee meeting on the 11 November 2019.

38.29 The Mayor then put the following Notice of Motion to the vote;

This council resolves to ask Environment, Transport and Sustainability committee to commission a report, exploring:

- How existing 10-minute walking zones around our schools can be optimised, adding the crossings and road calming measures necessary to create genuinely safe walking routes to school.
- How visual elements could be used throughout a zone to give drivers a clear message that they are near a school, walking families have priority, and drivers are guests in that zone.
- Funding options available to create these zones (such as grants, planning contributions, parking surplus, bids for funding)

And further, that such a report:

- sets out the ways in which the council will work in close consultation with schools and local communities about the creation of these zones.

38.30 The Mayor confirmed that the motion had been agreed unanimously and would be referred to the Environment, Transport & Sustainability Committee for consideration.

39 CALL OVER FOR REPORTS OF COMMITTEES.

(a) Callover

39.1 The following items on the agenda were reserved for discussion:

Item 44 - Review of Political Balance

(b) Receipt and/or Approval of Reports

39.2 The Head of Democratic Services confirmed that Item 44 had been reserved for discussion; and that the following reports on the agenda with the recommendations therein had been approved and adopted:

Item 42 - Adoption of the Shoreham Harbour Joint Area Action Plan
Item 43 - Attendance Policy and Procedures.

(c) Oral Questions from Members

39.3 The Mayor noted that there were no oral questions relating to the items that had not been called.

40 WRITTEN QUESTIONS FROM COUNCILLORS.

40.1 The Mayor confirmed that written questions from Members and the replies from the appropriate Councillor were taken as read by reference to the list included in the addendum which had been circulated prior to the meeting as detailed below:

(1) Councillor: Gibson

40.2 The answer to the below question was initially deferred till after the budget and then answered partially without revealing the modelling of actual costs for the specific schemes, so please provide the full answer to include all the specific schemes referred to in the question below?

"Can the new homes schemes modelled (in answer to question 8 to full council on April 19th 2018) as estimates (using estimates of borrowing and build costs) be modelled inputting the actual build cost and the actual capital charges (or if this is not easy to establish using the weighted average capital charge on actual borrowing taken out since 2015) of the loans used to fund the schemes over a 60 year period to establish the projected surplus/deficit based on more accurate inputs?"

Reply from Councillor Williams, Chair of the Housing Committee

The table below models each project updated using the current model and assumptions including actual costs and the average rate of borrowing during the period of 2.15%. Rental figures are based on the old LHA rates and previous Living Wage rates and are reduced by 1% over a 4-year period.

		Average Cost of borrowing 2.17%		***Treasury Green Book 3.5%***	
Scheme Name	***Previous Subsidy / (Surplus)***	**60 Year Subsidy / (Surplus) LHA £'000**	**60 Year Subsidy / (Surplus) 37.5%LW £'000**	**60 Year Subsidy / (Surplus) LHA £'000**	**60 Year Subsidy / (Surplus) 37.5%LW £'000**
Preston Road	*76*	(110)	40	30	140
Manor Place (South)	*329*	330	580	590	780
Manor Place (North)	*107*	(270)	(20)	(10)	180
Ardingly Street	*286*	(180)	70	70	260
Guinness Garage Sites	*385*	(400)	80	1 10	470
Kensington Street	*570*	(310)	790	810	1,170
Brooke Mead	*2,125*	(80)	1,500	1,650	2,820
Findon Road	*1,302*	(2,770)	430	330	2,710
Wellsbourne	*512*	(1,350)	(80)	140	1,090
Lynchet Close	*(203)*	(1,780)	(480)	(1,020)	(50)
Total(surplus)/deficit	***5,489***	**(6,920)**	**2,910**	**2,700**	**9,570**

The above table indicates that if the lower interest rate had been used when assessing the viability of these schemes, Wellsbourne (Hobby Place) and Lynchet Close may have been viable at 37.5% Living Wage Rents however, overall the schemes based on this rent level would be a net liability to the HRA and therefore a consistent approach is preferred to protect the HRA's financial position and long-term viability.

In evaluating the viability of schemes, using the rate of borrowing does not assess the long-term risk of building new homes for rent and ensure the future viability of the HRA. The borrowing undertaken was at a time when rates were unprecedentedly low and therefore it would not be prudent to assume these rates in viability modelling.

The current model uses the Treasury Green Book discount factor to establish the Net Present Value of schemes.

This allows for a consistent approach in modelling viability. Over a 60-year life of these assets, many of the variables are subject to political and economic forces. E.g., rents may be reduced over a prolonged period; management and maintenance costs increase above normal inflation or interest rates for actual borrowing may be higher than expected in the model.

Finance would be happy to discuss the findings further with Cllr Gibson

(2) Councillor Gibson

40.3 In the light of the recently announced changes to PWLB rates please can you update the costs provided in answer to the following question asked to Policy & Resources committee in February 2019;

Please provide a table showing the annual repayment required of BHCC on a loan at current PWLB rates for 5, 10, 20, 25, 30,35, 40 and 50 million pounds? (showing repayment periods of 30,40, 50, and 60 years for each loan).

Reply from Councillor Platts, Leader of the Council

The table below shows the annual financing costs of borrowing based on the Public Works Loan Board (PWLB) published rates on 17 October 2019. These costs are subject to the government's discount to local authorities. This is known as the 'certainty rate' which is 0.20% below the published maturity rate for standard new loans. These rates apply to maturity loans where the principal loan amount is repaid in one lump sum at the end of the loan period.

PWLB rates are updated and published twice daily on banking days and can fluctuate substantially over time primarily due to changes to the Gilts market and the Bank of England Base Rate, and therefore the information in the table is indicative only, i.e. different interest rates would result in different costs.

The annual cost is based on the council's Annuity Minimum Revenue Provision whereby the council sets aside repayments of the principle each year to meet the full loan repayment at the loan expiry date.

The parameters for the council's investment and borrowing are set within the Treasury and Prudential Indicators. The 2019/20 indicators were agreed at Budget Council on 28 February 2019 as part of the Budget Report.

	Period		
	30 years	40 years	50 Years
PWLB Certainty Rate	2.98%	2.88%	2.85%
Loan Amount	£'000	£'000	£'000
£5m	254	212	189
£10m	509	424	378
£20m	1,018	849	755
£25m	1,272	1,061	944
£30m	1,527	1,273	1,133
£35m	1,781	1,485	1,322
£40m	2,035	1,697	1,511
£50m	2,544	2,121	1,888

(3) Councillor Clare

40.4 How many complaints arose from events in Brunswick and Adelaide Ward so far this year?

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

There have been no complaints recorded by the Corporate Customer Experience Team regarding events in the Brunswick and Adelaide Ward since March 2019. There may have been informal enquiries or first stage complaints or received by individual services relating to a variety of incidents in the ward, but these are not recorded centrally and there is no mechanism to provide you will reliable date. If you have concerns about specific events or incidents, you can raise them with the relevant service and officers would be happy to supply you with the information.

(4) Councillor Nemeth – King Alfred

40.5 Starting with Councillor Geoffrey Bowden, who proudly launched the King Alfred project whilst Chairing the Economic Development & Culture Committee, please provide a timeline of lead Members for the project since Councillor Bowden, finishing with whoever is leading now?

Reply from Councillor Robins, Chair of the Tourism, Equalities, Communities & Culture Committee

When the King Alfred project was re-established in 2012, it was overseen by a cross-party Project Board chaired by Cllr Bowden. He chaired the Board for almost 3 years, through to the May 2015 local elections, following which the role of chair was taken by Cllr Morgan, the then Leader of the Council, and I'm aware that this is the point at which Cllr Nemeth joined the Board.

As a result of revised governance arrangements, all Project Boards were disbanded in mid-2016. They were replaced by the Strategic Delivery Board, a cross-party Member Board chaired by the Leader of the Council. Cllr Morgan therefore provided the lead Member role between 2016 and 2018, at which point Cllr Yates took on the role as the new Leader of the Council, and since May 2019 the Strategic Delivery Board has been chaired by Cllr Platts.

The Strategic Delivery Board receives a written update on major projects at every meeting and, as one of the most significant projects, the King Alfred was the subject of many detailed updates and reports.

Updates on Major Projects form part of the regular business of the Tourism, Equalities, Communities & Culture Committee, and also its predecessor committee (TDC), again as a standing item, through which I am briefed ahead of such meetings. I also receive regular briefings from the Executive Director Economy, Environment & Culture and Ward Councillors are briefed at key stages of the process as required.

Moving forward, as agreed at last week's Policy & Resources Committee meeting, a new Project Board is to be created for the next King Alfred project.

(5) Councillor Miller – Madeira Terraces

40.6 When on current projections are all 147 arches likely to be restored by this failing Labour Administration? Would they prefer the Conservative group to take over and have work start on all of them within 24 months?

Reply from Councillor Robins, Chair of the Tourism, Equalities, Communities & Culture Committee

We will be bringing an update report to Tourism Equalities Communities & Culture Committee on 21.11.19. The Administration has a business case which can unlock funding for the first 30 arches and an update on this will be provided for committee. This will include a timeline for the appointment of a full design team, funded by the council, to further progress the design and option analysis for the structure.

(6) Councillor Miller – Private Schools

40.7 Does the Leader of the Council, and her colleague MP's, agree with the Labour Party that successful schools in our city, educating many local pupils, such as Brighton College, Roedean, Lancing College and St. Christopher's to name but a few: should be closed down, and stripped of their assets? So as to increase the financial and land pressure on our local maintain, free and academy schools and ultimately lower standards and outcomes for all our city's young people?

Reply from Councillor Platts, Leader of the Council

Across the city we have a well-established education partnership which has previously extended an invitation to a representative from the independent school sector. Some of our schools have been working in partnership directly with local independent schools and relationships have been positive.

I would encourage the Councillor to take another look at Labour Party national policy, as it makes no reference to closing down or asset-stripping independent schools, but rather to integrating them into the state sector.

What it does refer to is:

- removing the VAT exemption on private school fees and using this to fund free school meals for all primary school children.
- reversing swingeing Tory cuts to ensure our schools are properly resourced.
- reducing class sizes to less than 30 for all five-, six-, and seven- year-olds.
- tackling the teacher recruitment and retention crisis by ending the public-sector pay cap.
- putting £150 million back into supporting our children in schools by scrapping the Conservatives' nonsensical plans for schools to pay the apprenticeship levy.

On our local state sector provision, I'm proud that we are seeing improvements in standards of education across the city. Standards in the City including attainment at KS1, 2 and 4 are already higher than National Averages. The percentage of good or better schools in all phases are well above National Averages. In secondary 100% of schools are Good or better.

Whilst the Conservative Government tries to impose academisation on Moulsecoomb Primary School, against the expressed will of 96% of parents and Councillors of all stripes in this very chamber, we know that under local authority direction the school has readily improved. The council now have a significant amount of evidence of improvement demonstrating the school should no longer be classed as inadequate. This includes improved attendance and outcome data at all key stages. Notes of visits from National Leaders of Education and experienced school partnership advisers comment on improvements in teaching and learning and behaviour for learning. We are confident our statement of action has meant that the school has improved to such a place that academisation would be pointless.

This Labour administration is supporting the children and teachers and standing with the parents and carers who voted overwhelmingly to keep their local primary school in local authority control, and the government must listen to them.

(7) Councillor Fishleigh

40.8 Is it possible for Cityclean to allocate two people to spend one day a week every week maintaining the area around Brighton train station so that this gateway into the city is more appealing to both residents and visitors with regular tasks to include painting over and scrubbing away graffiti, peeling off stickers and painting over the damage caused by them on lamp posts, repainting the black railings, weeding and tendering plant beds?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

Brighton Station and Queens Road has one street cleaner on a daily basis, Monday – Sunday starting at 5am until 1pm. They start at Brighton station and finish at the clock tower at the end of Queens Road. The responsibilities of the individual on duty are to sweep any litter and detritus and clear any weeds. We also have a Street Cleanser on an afternoon shift who will litter pick the above area.

We are removing all graffiti from council buildings and highway furniture. We have two operatives working on the removal of graffiti between Saltdean and Mile Oak. We need to treat offensive graffiti as a priority, so non-offensive graffiti will be removed in due course.

We are currently working on a new graffiti removal approach where we implement zones for certain areas, at the moment we are working on zone 1 which is the North Street area, zone 2 begins at Queens Road which we will be working on in the near future. This also includes the removal of stickers.

We are also checking the seating area in front of the station, and the area is treated with a high-pressure jet washer regularly.

With regards to the flower beds, we keep them tidy; however please do let Cityclean know if there are any concerns on the standard of them.

Unfortunately, we have limited funding for highways maintenance and this is prioritised to ensuring that we are able to maintain the highway, leaving little funding for the routine painting of railings and lampposts.

As you may be aware, members of the community through the Tourism Alliance have been doing a good job in recent months of maintaining the area around the station, voluntarily planting flowers and replacing benches

Proposals for enhancing the area from the station to the seafront will be outlined in the Gateway to the Sea report which will be presented to ETS Committee in November.

We are also working with GTR to move the taxi rank to the back of the station next month which will reduce congestion, improve air quality and open up the front of the station making it a much nicer entrance to the city.

(8) Councillor Hugh-Jones

40.9 On 1 October 2019, the Government opened the consultation on Future Homes Standard by 2025. The consultation ends on 10 January 2020. The government withdrew the Code for Sustainable Homes (CSH) in March 2015 following which this Council had to fight hard to incorporate the equivalent of CSH Level 4 into City Plan Part 1.

Unsurprisingly, more recently, in its report on energy efficiency, the Business, Energy and Industrial Strategy (BEIS) Committee also described it as "*nonsensical to be continuously making the problem worse by allowing new homes to be built that will also need to be retrofitted".*

In relation to existing housing stock, the Committee on Climate Change noted in its 2019 report to Parliament that:
Policies are not in place to deliver the Government's ambitions on energy efficiency … Building standards are not sufficiently enforced … Regulations for the private rented sector prioritise costs for landlords over running costs for renters. MHCLG must play its part, including minimum standards for social housing.

Does this administration plan to respond to the consultation? If so, and in light of the climate emergency, will the Council explore, as a matter of urgency:

1. The adoption of the Scottish model of making zero interest or equity loans available to homeowners for energy efficiency improvements, or an equivalent model?
2. Better enforcement of energy efficiency standards including, in the private rented sector, lobbying for the removal of the £3500 cap on landlord's fuel efficiency improvements?

Reply from Councillor Williams, Chair of the Housing Committee Proposed response:

The Housing Committee Work Plan 2019 – 2023 agreed at Housing Committee on 18 September includes the following priorities:

- Improving the quality of the private rented sector, including researching and reviewing an ethical loan scheme and developing the enforcement approach to private sector housing to reflect the full range of potential enforcement options available to improve and manage standards.
- Achieving carbon reductions and sustainability in housing, including addressing fuel poverty and developing a policy to set out how we will work collaboratively to ensure housing contributes to making the city carbon neutral by 2030.

The council is already supporting the Warmer Sussex project with Retrofitworks, to improve the energy efficiency of homes across Brighton & Hove and the wider Sussex area.

The council will explore energy efficiency loan options and private rented sector enforcement and lobbying opportunities through the reports we are committed to bringing forward to Housing Committee under the Workplan.

The council will be responding to the consultation. We will use opportunities as they arise to respond to consultation and lobby government on elements of the regulations that we see as restricting improvements to energy sufficiency standards in the private rented sector.

(9) Councillor Gibson

As of 1st if October 2019, please can you tell me, across Brighton and Hove how many:

- CPZ permits were issued?
- What the annual cost average charge per permit?
- How many addresses have each of 2, 3, 4, 5 permits issued?
- How many vehicles have permits for 2 zones?

Reply from Councillor O'Quinn, Chair of the Licensing Committee

i) CPZ permits were issued?

There are currently 40379 valid permits, of which 38843 are resident permits.

ii) What the annual cost average charge per permit?

The average cost of all current active permits is £136.06. This figure includes permits purchased for 3 months, so does not represent the annual cost per permit.

The annual costs of resident permits are as follows:

For zones A, C, E, F, G, H, J, M, N, O, Q, T, Y, Z; £130 annual (£180 if paid quarterly)

For Zones U and W; £100.00 annual (£120.00 if paid 6 monthly).

There is a 50% discount for low emission vehicles and a 25% increase for high emission vehicles.

A full list of fees and charges for all permit types are available in this pdf document.

https://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/Fees%20and%20Charges%202018%20-%2019.pdf

iii) How many addresses have each of 2, 3, 4, 5 permits issued?

There are 22,708 addresses in the city with one permit, 4570 addresses with two permits, 927 addresses with three permits, 303 addresses with four permits and 136 addresses with five permits. There are a further 287 addresses with six or more permits, however these tend to be linked to large businesses, organisations, doctors' surgeries or hospitals.

iv) How many vehicles have permits for 2 zones?

We do not have any reports available that show how many vehicles have multiple permits issued to them.

(10) Councillor Osborne - **Students and noise complaints in Coldean**

40.10 What is the council doing to put pressure on the bus companies, the university and other stakeholders to address the issues caused by anti-social behaviour in Coldean coming from the Varley Halls?

Reply from Councillor Pissaridou – Chair of the Environment, Transport & Sustainability Committee

Officers have had a meeting on site with representatives of Brighton & Hove buses, the University of Brighton, the students' union, Sussex Police and the local community to discuss the issues and options which could improve access to the halls.

Officers from the Community Safety team have also attended subsequent "round table" meetings and in response to recent reports have visited affected residents, met separately with the University and been in contact with the police and other residents and stakeholders including all the local councillors.

The bus company are currently unable to access the estate road because of the unsuitable camber of the estate road but this would require significant and expensive engineering measures to a private road which unfortunately the Council would be unable to fund because it has no obligation to do so and its spending priorities are focused on the public highway network.

Brighton and Hove Buses are currently unable to access the estate road because of the camber of the highway at the junction of the road. This would require significant and expensive engineering measures, mainly to the public highway. The University is currently commissioning work to assess what this would entail. While the Council is under no obligation to give permission or fund these works, we are keen to work together with all parties to try and find a solution. Discussions are also being had with Homes for Brighton and Hove to ensure that highway works done in connection to the recently approved development adjoining Varley Park contribute positively as much as possible to the resolution of these problems.

(11) Councillor Osborne - Advertising- removing sugary/fatty foods and drinks

40.11 Dame Sally Davies, Chief Medical Officer for England, recently announced that one of the best ways to tackle the obesity epidemic in children is to cut out advertising of unhealthy food and drink.

Does the council lease any land/property to advertising companies? Does the council have powers to restrict advertising in places which it doesn't own and does the council intend to use its authority as a licensing body to limit the advertising at events?

Reply from Councillor Pissaridou – Chair of the Environment, Transport & Sustainability Committee

The council has 3 licenses in situ on land/property with advertising company JC Decaux.

These produce minimal income for the council with limited restrictions on content. The restrictions relate to only displaying material that confirms with statute (including in particular the planning obscenity sexual and racial discrimination and health laws) and with the codes promulgated by the Advertising Standards Association (or any successor body) and which is not otherwise unlawful or offensive and immediately on demand to remove and replace any material displayed in breach of this sub-clause.

The council also owns 478 Bus shelters and 5 taxi shelters in the city (excluding Heritage style shelters, which are maintained by Cityclean and do not carry advertising).

Of these 223 are advertising shelters and the council grants a concession contract to Clear Channel UK to advertise on these shelters in return for an annual income and the cleaning and maintenance of the shelters. Contract management is undertaken by the Public Transport Team.

Our contract with Clear Channel prohibits certain kinds of advertising e.g. tobacco and gambling, and restricts others, e.g. advertisements directed towards children.

Advertisements for alcoholic drinks should not feature in promotions directed at people under 18. Advertising for alcoholic beverages or fast food takeaways should not be sited within 100 meters of any school or youth club ,or NHS building or public sector

building/premises/facility/park/leisure centre primarily used by those under the age of 18 (or their guardian or carers).

In regard to the advertising boards next to the King Alfred Car park this arrangement with Clear Channel is managed by the Traffic Control Centre. They are currently reviewing this arrangement and will ensure your concerns will be considered taking into account the issues outlined with other advertisement contracts.

(12) Councillor West

40.12 Electric cars offer an opportunity to reduce air pollution, though will not address road congestion and the danger faced by active and vulnerable road users. While it is hoped electric cars will be powered with renewable energy, the energy levels required to power large scale use of electric cars will need a huge investment in generation, transmission and charging infrastructure. When account is also taken of the high level of embodied energy needed to produce electric cars, what overall carbon saving can be achieved through switching from conventionally powered to electrically powered private vehicles? Given the Labour administration shares the Green goal of the city being carbon neutral by 2030, does the Labour administration accept that electric cars are not a panacea for carbon neutrality and that instead there needs to be a rapid and major shift from car use to active and sustainable travel modes in the city?

Reply from Councillor Pissaridou – Chair of the Environment, Transport & Sustainability Committee

I think your first question about the total amount of energy consumed by all of the processes associated with the production and use of electric vehicles and their associated infrastructure is probably better asked of the Government.

Regarding your second question, I don't think that any political party would describe electric vehicles as a panacea to the global climate emergency that is now at the forefront of so many people's thoughts and actions, and which is now the driver for many policies and priorities.

However, electric vehicles can undoubtedly reduce harmful emissions from transport in local areas and communities; and for those people who can drive and can afford to switch, it is good that they have that choice and it is a sensible decision to make.

The city's fantastic bus services provide people with a great opportunity to travel over distance, and we aim to do more with them as part of our Quality Bus Partnership. More electric buses on routes crossing the city will make a significance difference in the city centre and the local neighbourhoods they connect.

We have eight train stations in the city – potentially untapped capacity for people in some parts of the city to get around more easily.

And the added benefits to people's health of walking and cycling must not be underestimated either, and that is why we are working on the development of a Local Cycling and Walking Infrastructure Plan, so that we can make those forms of transport the first choice for as many local journeys as possible.

As you are also aware the Council is developing its next Local Transport Plan where reducing carbon and improving air quality will be a significant consideration in its inception.

(13) Councillor Mac Cafferty - Communal Bins

40.13 Can you please tabulate:

(1) the quantity of complaints about communal bin collections;

(2) the quantity of complaints about the state of communal bins and;

(3) the age of each communal bin,

on each street in Brunswick and Adelaide Ward for the past five years?

Reply from Councillor Pissaridou – Chair of the Environment, Transport & Sustainability Committee

This information is not available as complaints have not been recorded in this way. There has been a recent change to how complaints are recorded and "issue with a communal bin" has been included.

The communal bin audit currently taking place is capturing a number of details for the bins, including their condition. This will help us determine whether any repair work is needed, or if a bin needs replacing.

(14) Councillor Mac Cafferty – Pavement Parking

40.14 Further to Scottish Parliament legislation and the Commons' Transport Committee recommendation to implement a ban on pavement parking in England, what will be done ahead of legislation in the meanwhile to enable our council to sign up to the Living Streets "Pavements for People" charter?

Reply from Councillor Pissaridou – Chair of the Environment, Transport & Sustainability Committee

The Commons' Transport Select Committee has recommended in the short-term allowing councils outside London to enforce against 'unnecessary obstruction' to combat the worst incidents of pavement parking. Longer term it has recommended that central government should work towards introducing a complete pavement parking ban unless signed to allow pavement parking.

In advance of any pavement parking ban the council would need to carry out a survey of all streets in the city to decide in which streets pavement parking was to be allowed in the city. Consultation with residents in streets where pavement parking is widespread would also be necessary before a decision on whether the pavement parking ban would apply to that street.

So ahead of the legislation, enforcement officers currently issue warning notices to vehicles parked on the pavement where a Penalty Charge Notice cannot be issued to discourage pavement parking.

We look forward to hearing the government's response to the Transport Select Committee's recommendations and will be ready to carry out citywide surveys if a pavement parking ban is agreed.

(15) Councillor Mac Cafferty – Licensing Complaints

40.15 Can you please tabulate the quantity of complaints about licensed premises for each street in Brunswick and Adelaide Ward in the past five years?

Reply from Councillor O'Quinn – Chair of the Licensing Committee

Street Name	Count
Brunswick Street East	7
Church Road	6
First Avenue	1
Holland Road	5
Lower Market Street	1
Montpelier Place	1
Norfolk Place	3
Queens Place	3
Upper Market Street	1
Waterloo Street	8
Western Road	38
Total	74

(16) Councillor Mac Cafferty – Anti-Social Behaviour Policy

40.16 Can you please tabulate the quantity of anti-social behaviour incidents for each street in Brunswick and Adelaide Ward in the past five years?

Reply from Councillor Childs – Lead Member for Community Safety

The Community Safety Casework Team has only kept records by ward since 2018/2019.

During 2018/2019 the Community Safety Casework Team received **50** new reports of or enquiries regarding ASB in Brunswick and Adelaide ward. Some of these reports will lead to the Community Safety team opening a case and co-ordinating a multi-agency response to the problem, during which further reports of ASB may be received e.g. Norfolk Sq, Brunswick Sq, Waterloo St

During the first two quarters of 2019/2020 the Community Safety Casework Team received **10** new reports of or enquiries regarding ASB in Brunswick and Adelaide ward.

Street name	**New reports of or enquiries regarding ASB**
Adelaide Crescent	6
Bedford Place	1
Boundary Passage	1
Brunswick Place	2
Brunswick Rd	1
Brunswick Sq	10
Brunswick Street East	2
Cambridge Rd	4
Farman St	4
First Avenue	1
Holland Rd	2
Hove Lawns	4
Lansdowne St	3
Norfolk Sq	2
Palmeira Avenue	1
Palmeira Yard	1
Upper Market Street	3
Waterloo St	7
Western Rd	1
Wilbury Villas	2
York Rd	2

(17) Councillor Mac Cafferty - Fixed Penalty Notices for Environmental Offences

40.17 Can you please tabulate the quantity of fixed penalty notices for environmental offences of littering, graffiti, fly posting and fly tipping respectively for the last five years across the city?

Reply from Councillor Pissaridou – Chair of the Environment, Transport & Sustainability Committee

Littering	Graffiti	Fly Posting	Fly Tipping*	Total FPNs
8382	*27*	*75*	*1734*	*10,218*

Statistics provide in the table above are from 01/03/2016 to 17/10/2019. We do not have data before this date

**Fly Tipping total includes both residential and commercial Fly Tipping.*

(18) Councillor Hills

40.18 Residents in my ward are keen to recycle as effectively as they can, but it can be difficult to access information about the whole range of what they can recycle and where. One comprehensive digital map that contains all public recycling points, as well as other non-council recycling services, would be really helpful. There are maps on the council website that show where specific materials/items can be collected, that is, cartons, electricals and textiles/clothes/shoes. But would great if all recycling points could be on one map, with pull down options so users can look up recycling facilities for specific items or materials. It is particularly difficult for residents to find out about non-council recycling options and it would be great if these could be included on the map too. Recycling services such as the Green Centre collect a wide number of materials but only at specific locations on particular days, and it would really help residents if information on services such as this could be available in the same place as council information. It could help residents to locate supermarkets that collect plastic bags, and garden centres that take plant pots too. The A-Z on there at the moment is useful but the provision would be better if such a map were available too, as people generally respond better to information presented visually. I'm sure my residents would really appreciate this as many don't have cars and would prefer to recycle as locally as they can.

When do we expect a food waste collection service be available in the city?

Reply from Councillor Pissaridou – Chair of the Environment, Transport & Sustainability Committee

We are making improvements to help residents recycle more easily through the Increasingly Recycling Project within the Modernisation Programme. This includes:

- Improving the content on the website
- Improving the communal bin system to include colour coding and better signage
- Improving the quality and frequency of recycling communication sent to residents; this started over the summer and will pick up again over Christmas; (different communications are being prepared for different stakeholders)
- A programme of work with crews on how to manage contaminated waste receptacles
- Closer working with other council services in regular contact with residents
- Monthly attendance at the Green Centre to support their recycling initiatives

We are looking to bring an options paper to Environment, Transport & Sustainability Committee in 2020/21 regarding a food waste collection service. Introducing a food waste collection service will be costly to the Local Authority. The government is

considering introducing mandatory food waste collection by 2023. The government has said that it will provide funding to assist Local Authorities to introduce this. However, in the interim we will continue to explore options to introduce a food waste collection service prior to 2023.

The options for a food waste collection need to be considered in the context of the wider work being completed on round restructures. The experience of other councils shows that the positive impact of a food waste collection service is maximised when kerbside refuse collections are moved to fortnightly and recycling collections moved to weekly. Food waste is then collected with recycling. These options will be explored during the engagement on round restructures.

The council can provide compost bins, wormeries and Jennys for recycling food waste at a reduced price. These can be purchased via the council's website.

The Brighton & Hove Food Partnership administer a community composting scheme for residents who do not have a garden but would like to compost their food waste. This scheme has been partly funded by the council and we are exploring options with B&H Food Partnership to extend the scheme further.

41 ORAL QUESTIONS FROM COUNCILLORS

41.1 The Mayor noted that 15 oral questions had been received. The Mayor stated that 30 minutes were set aside for the duration of the item.

41.2 Councillor Mac Cafferty asked the following question, A few weeks ago councillors might recall that the Government announced a rise in the PWLB loan rate of 1%. That may sound innocuous the reality is that it means for us like councils around the country that there is another huge cut coming. It came also in the same week that council houses won the Stirling prize and the councils announced that they are going to building 80 thousand new homes before 2025. The LGA calculates this could cost all of us another £70 million a year. I have a few questions and I am wondering if the Leader of the Council agrees with me that this move is damaging to the local government especially at this particular time? Also, what analysis and assessment has been done to understand what this might actually mean to us and indeed what contingencies do we have to deal with the change regardless of the damaging move, so we aren't hurt significantly?

41.3 Councillor Platts replied, Firstly, I want to reassure the councillors that the PWLB interest rate rise does not affect the i360 financing arrangement. The loans for the i360 were taken out between 2014 and 2016 at fixed interest rates.

It is not helpful to have interest rates raised and there are other market lenders that we can look at for more competitive rates. If you require more information I can provide a written response.

41.4 Councillor Mac Cafferty asked the following Supplementary question, Given that the government has announced this without consultation would the Leader of the Council join with me in writing to the Secretary of State for Communities to condemn the move?

41.5 Councillor Platts replied, Yes, I would be happy to do that.

41.6 Councillor Bell asked the following question, Is the Administration pleased with the £14 billion that has been provided as extra money for school funding?

41.7 Councillor Allcock replied, Yes of course we welcome any money having been starved of funds for years. I had not been told it was £14 million, I have 5.2million for schools and 2.8 million for the special needs sector, but I will check up on your figure. School funding is complex School funding is complex and needs to take account of various grants, costs being met directly by schools, directly by local authorities and on occasion jointly.

Over the last four years the budget for schools in the city have risen due to an increase in the pupil population, but this rise has not kept pace with costs which have risen much more including a 13% increase in teacher pension costs without an increase in funding to cover this. In addition:

- Local Government pension costs for other school staff have also increased equating to a 4% increase for schools.
- National Insurance rates have also increased by 4%.
- Finally, general inflationary costs equate to a further 5% increase in school costs.

So overall, pay and other costs have risen by around 24% for schools between 2010 and 2019. This is compared to overall funding increases for schools of around 14%, obviously leaving schools with a significant shortfall in funding over the period.

The 3.9% increases in the schools funding block that we anticipate receiving in the financial year 2020/21 is appreciated and will begin to address the huge funding gap that has been the legacy of Conservative Government cuts to our Children and Young People's Education.

Conservative cuts are starving our schools of the funding they need to deliver a first-class education. Crippling underfunding is driving up class sizes and forcing schools to cut corners. A narrow curriculum and a culture of assessment is driving away teachers, creating a recruitment and retention crisis.

I am sure that bit of money will help as we have a lot to replace of what has been taken away.

41.8 Councillor Bell asked the following Supplementary question, I agree that cuts are a bad thing, can the Administration explain why they are cutting £1.9 million out of all our schools funding by refusing to pay out the term funding which they have been struggling with. We have been approached by the Schools Forum who have explained they are struggling, and this Administration has said 'you must fund this yourself'.

41.9 Councillor Allcock replied, I assume you are referring to term time only backpay. New national guidance following a court case relating to term-time only staff has made it clear that these staff are owed some back pay. The previous system had been used for many years and was established practice across the country. This ruling has had a major impact nationally and affects many staff locally.

There is no national formula for working out exactly how much people are owed. Following formal negotiations with our trade unions, with whom we work very closely, we have reached a local agreement on how much our term-time only staff are owed. We are doing everything we can to make sure all school staff affected are paid what is owed to them before the end of the year.
We are writing to staff due a back payment on an individual basis to make sure we can sit down with them to agree the payment and do the paperwork needed to make this possible. In strict legal terms, the cost of these back-pay liabilities falls to individual schools, not the council, but we are very aware that school budgets as I have referred to earlier are under a lot of pressure and we recognise that the back-pay liability is a big one-off financial burden for our schools. But the same is true of the council, we've had massive reductions in government funding over the last ten years £100 million and we are currently waiting to hear exactly how much funding the government is going to give the council for next year.

So, despite the continuing funding reductions the council is facing, we are committed to sharing the financial burden of this payment with our schools. We have offered to meet 50% of the back-pay liability. We are also offering to pay our schools' 50% share of the bill upfront and allow them to pay us back over 10-years. We have done this by making available reserves being held for future projects that aren't needed in the short term. However, we listen to people because we want to know what is going on we listen carefully to what our schools are telling us, we have offered to suspend those repayments during this financial year and the next one, while the individual settlements with staff and future government funding allocations are being worked out. During this period, we are determined to consider all options.

We recognise that some schools will be more affected by this issue than others and have undertaken to look at each school's needs on a case-by-case basis. We will be discussing this issue further with our headteachers at our next Schools Forum meeting and that feels like the most appropriate way to go."

41.10 Councillor Hugh-Jones asked the following question, Following on from my written question in July and subsequent correspondence between Councillor Pissaridou, myself and one of my residents who has been voluntarily monitoring the performance cleaning contract in relation to the Blakers Park facilities specifically. Has the Administration considered the health and safety and qualities impact of the contractor's poor performance? I say this because quite often public toilets are quite often located close to children's play areas and are relied on by those children but also, they are frequently used by older people, those with disabilities and men with prostrate issues. Given the contractor's poor performance why does it get a green rating in the Procurement Advisory Table? Is the contract being properly monitored?

41.11 Councillor Pissaridou replied, City Clean continue to work with Healthmatic, who are contracted to carry services at public conveniences across the city. There have been some ongoing issues with the delivery of the contract and we are working together to resolve these. The standard of service and staffing issues has been escalated to senior management of the company and we are asking them to address this with urgency. We are liaising with the council's legal team to identify options to help

manage and resolve the concerns we have with the service received from the contractor.

41.12 Councillor Hugh-Jones asked the following supplementary question, My resident submitted a freedom of information request in relation to this contract she then challenged a number of the original answers she received as either not answering her questions or being incomplete. Of her 24 original questions she had further questions on 18 of them. Her complaint was subsequently upheld, so my question is how come unreliable and incomplete information was provided in relation to the FOI in the first place?

41.13 Councillor Pissaridou replied, I understand that the Assistant Director of City Clean met with your resident this week, so I think that has gone a little further than what you have set out. I have nothing further to add to this because it is a very sensitive are other than to say, as you know, we are taking these concerns very seriously indeed and will do whatever necessary to resolve the situation.

41.14 Councillor Barnett asked the following question, Everywhere you look the city is full of graffiti it is filthy this look is completed by rubbish on the pavements. What impression does this give to visitors on which we rely on for revenue. It is not doing our credibility any good. We are known as a protest city not as a nice place to spend a week away. The state of this city is not due to the cost cut of spending, other towns and cities also have experienced the same cuts as the south but wherever you go in the south coast everywhere else is brighter and cleaner, Brighton & Hove has deteriorated a lot in the recent years and is now far from the place that attracted tourists and holiday makers, bringing their money with them, now the city does not hold any attraction other than for protesting. Why are we just sitting back and letting this happen? Why do people feel they can deface the city with graffiti and rubbish and are allowed to carry on doing this, where has our pride gone? we seem to be sinking under a wave of dirt, graffiti and rubbish, nothing seems to be being done this is not down to funding cuts it is down to people turning a blind eye to not wanting to do anything about the state of the city and not caring. In the paper today and again last week there were photographs of people defacing the walls. Why are we not fining and making them clear their mess up?

41.15 Councillor Pissaridou replied, What I do have to say is to contradict what you say, by 2020, local councils will have faced a reduction to core funding of nearly £16 billion over the preceding decade. That is the reality of nearly 10 years of Tory Government and residents are seeing the consequences of those cuts.

Despite this, we are taking steps to modernise our services and we are consulting the local community on how we can work together to keep the city clean, including the best way to eliminate graffiti and tagging. We've already introduced fines for littering, including spitting chewing gum and for fly tipping. We would welcome any representation by Cllr Barnett, if she would like to, to make her friends in government, on the need for increased funding in local services which would support these efforts. Despite this, we are taking steps to modernise our services and we are consulting the local community on how we can work together to keep the city clean, including the best way to eliminate graffiti and tagging.

We have introduced a consultation on graffiti we have already had 711 responses in one week and they are all positive that they want the council to take some action on persuading businesses and the private sector to do something about their graffiti and we are helping them to do that. So, we have got so many initiatives with graffiti being one of the main ones.

41.16 Councillor Barnett asked the following supplementary question, Everyone has had cut backs and everywhere else they do the basics without wasting money.

41.17 Councillor Pissaridou replied, I did not get another question, but I have found my note on tourism. The latest figures on tourism show a positive response across the board, day trips up by 1%, direct business turnover increased by 4% to 335 million, overnight stays domestic visitors up by 7%, overseas visitors decreased by 4%. But across the SE as whole the increase was 23% down so we are 'bucking the trend'. On graffiti the figures on the consultation 716. We can't enforce other businesses to remove graffiti on their premises, but public pressure will do so. Of 70% of those that responded said that statutory undertakers should remove their own graffiti and over 70% said large businesses should remove their own, so we are on track.

41.18 Councillor Fishleigh asked the following question, Anyone who listens to Radio Sussex or Drive Time on Radio 2 knows that the A259 between Brighton Marina and Newhaven is in trouble, despite falling traffic volume congestion is increasing and seriously affecting the bus services. A detailed survey of traffic flow on the A259 between Eastbourne and the Aquarium is currently being conducted, it is funded to tune of £100,000 by Lewes District Council. Consultants and officials working on this survey have repeatedly asked Brighton & Hove Council to share information about traffic flows in its part of the A259. Will Brighton & Hove City Council please commit to researching and sharing all the information that the A259 traffic consultants need by Christmas so that their report isn't delayed.

41.19 Councillor Pissaridou replied, I believe that you are referring to a planned study of the A259 which is carried out by East Sussex County Council. Once the city council has a clearer understanding of the nature and extent of that study, it will be able to fully consider what information may be available to help to inform it. ESCC and LDC arranged a meeting in March 2018 to 'share the current evidence base and explore short, medium- and long-term strategies in relation to congestion of the A259.' The then Chair of the ETS Committee attended that meeting. Other invitees included local MPs, Leaders and Lead Councillors of Lewes District, East Sussex and Brighton & Hove, plus council, Local Enterprise Partnership, National Park Chief Execs and/or Senior Officers. An independent consultant was commissioned to make a presentation about the A259.

Later in 2018, ESCC announced that it intended to fund a study of the A259 in 2019/20. LDC subsequently agreed to allocate £50,000 to the study. BHCC has not been approached for, or made, any similar financial commitment as part of its revenue budget.

41.20 Councillor Fishleigh asked the following supplementary question, These consultants have asked the council for information and it is not forthcoming so can somebody at the Council get on the case as it is delaying the report?

41.21 Councillor Pissaridou replied, There is no further information currently available to enable officers to fully consider the implications and opportunities to the city council and its partners, stakeholders and local communities to actively engage with the study.

41.22 Councillor Ebel asked the following question, To my surprise the Conservative Group did not attend the extraordinary Council meeting to debate the effect of Brexit on our city. Does the Leader of the Council condemn the practice of signing the attendance register only to then boycott the meeting?

41.23 Councillor Platts replied, I think it is unacceptable for people to sign in as if they are attending the meeting and then not actually attend.

41.24 Councillor Ebel asked the following supplementary question, On the day of the extraordinary Council meeting Cllr Steve Bell was reported by the Argus saying that this meeting was a waste of tax payers' money. I was born in the GDR and have lived my first few years in a place that was not a democracy I therefore value democracy very highly. What we saw on 3 October was a conservative party that shied away from a debate on a mess that they have created. Does the Leader of the Council agree that democracy is never a waste of money and that residents have a right to be informed about the consequences of the Brexit mess that the Conservative party has left this country with?

41.25 Councillor Platts replied, I agree with you that as long as it is within the rules we have a perfect right for a want to call a debate and it is very important for democracy to be done.

41.26 Councillor Mears asked the following question, Can the Deputy Chair of Housing inform us what extra work is taking place in the city along with the 18 services including St Mungo's that help the Housing Department are already working with and also with the police. We know that alcohol and drugs are an addiction and are killing rough sleepers and homeless on the streets and she is aware of the organised gangs now working in the city from London Road to Portslade. Although it is applaudable to be providing extra accommodation for homeless shelters prevention is paramount because it saves lives and without that going forward we can build and spend as much money on extra shelters but unless we bring prevention in very firmly more and more people will die on our streets.

41.27 Councillor Brennan replied, Lack of prevention is due to the cuts that have been made to substance misuse and mental health primarily. The only way we will prevent people from going on to our streets and taking the drugs and alcohol that they have to take to get through their day will be when we stop this austerity, when we stop Universal Credit, when we stop these awful ideologies that we have. When we take away people's nets they fall through them and what we are seeing is that we are having to sweep up the mess. I firmly believe in treatment and consulting rooms for people that are taking drugs on the street, but all this is going to take money. I believe that people should have shelter and it is not a privilege. If that means setting up night shelters, then albeit and if it means taking them off the streets when it is pouring with rain for 5 days then let's do it.

The council are doing a lot and I, like you, would like to make sure that the money is going to the people on the streets and not into middle management and into big charities etc. I am here really for this purpose, I want to stop the chaos on the streets I see people who have been out there for 2 years it is so entrenched that it is all they know, and I would like to help those people feel better about themselves so that they don't want to keep going out and begging.

The gangs, I was straight on to them if they are exploiting people, they move around, and I am very aware of them and they are very aware of me and I am in contact with the community safety team within the council. We also have women on the streets, women should not be sleeping on the street ever. It is like going back to the 1800s and they are plying their goods for a sip of gin, that is reality out there being accosted by men for sexual tricks and all the sexual disease that people have, and it is something that this Administration is compassionate about we want to solve this. That will mean asking for more money in the next budget.

41.28 Councillor Mears asked the following supplementary question, Thank you for your response, I think it is important to point out that alcohol and drug addiction is not necessarily afflicted on people on lower incomes it can be anybody from any walks of life, it isn't necessarily around austerity but we are seeing on our streets more and more rough sleepers and homeless and if you look at them you can tell that there is a serious addiction in this city and we also know and are aware of the gangs coming into the city to put people on the streets begging and that needs to be addressed because it deters from actually dealing with those that absolutely need the council's and other organisations help but it is growing out of all proportion.

Going forward is there going to be a new homeless and Rough Sleepers' Strategy? Over the years, it wasn't that long from the previous Labour administration's strategy and we have some many strategies and policies within the council, I don't know where they end up, but I would request and hope on the new strategy that they check through the old strategy so things that work, that make a difference are put into the new strategy.

41.29 Councillor Brennan replied, My priority, and I am very aware of the drug and alcohol problem in the city, from teenagers and you are right it doesn't just affect people of low incomes, is the people on the streets and how can we do that? It is by having more treatment centres, more detox beds and this is all the stuff that I want to bring into the strategy I agree with this.

41.30 The Mayor noted that the 30 minutes set aside for oral questions from Members had been reached and therefore the remaining eight questions would be carried over to the next meeting.

42 ADOPTION OF THE SHOREHAM HARBOUR JOINT AREA ACTION PLAN

42.1 **RESOLVED:**

(1) That the response to the consultation on the main modifications to the JAAP and the contents of the Inspector's Report with her conclusion that the JAAP is legally complaint and 'sound' be noted;

(2) That the JAAP be adopted, incorporating the main modifications and minor modifications as part of the Development Plan for the City, subject to the Head of Planning agreeing any further minor non-material changes to the text with Adur District Council and West Sussex County Council;

(3) That the currently adopted west area Policies Map be revised to additionally display policies contained within the JAAP;

(4) That the Development Brief for South Portslade Industrial Estate & Aldrington Basin be revoked.

43 ATTENDANCE POLICY AND PROCEDURES

43.1 **RESOLVED:** That signing up to the TUC's *Dying to Work Charter,* which supports staff with terminal illness to either remain in work as long as they are able, or to help them to access their pension early, depending on their wishes be agreed.

44 APPOINTMENTS &REVIEW OF POLITICAL BALANCE 2019/20

44.1 Councillor Mac Cafferty noted that the appendix to the report listed eleven members of the Planning Committee rather than ten and sought confirmation that the Conservative Group's allocation would be reduced to two rather than three Members.

44.2 The Head of Democratic Services apologised for the error and confirmed that the Conservative Group's allocation would be reduced to two Members and that confirmation of who would be coming off the committee was awaited.

44.3 Councillor Bell stated that he would ensure that the Chief Executive was informed of the Group's changes and that he was aware there would only be two seats on the committee.

44.4 The Mayor noted the information and moved that the recommendations be agreed subject to the Planning Committee's membership reflecting the approved membership of 10 Members.

44.5 **RESOLVED:**

(1) That Councillor Allcock be appointed as the Deputy Leader of the Council;

(2) That the Council confirms the appointments to those Committees and Boards affected by the changes between political groups as set out in appendix 1 to the report, (subject to the Planning Committee being 10 Members on the basis of 3:3:2:1:1);

(3) That it be noted the vacant places shown in appendix 1 will be notified by the respective Group Leaders;

(4) That the following appointments be confirmed:

(a) Councillor Allcock as Chair of the Corporate Parenting Board;
(b) Councillor Evans as Chair of the Asset Management Board;
(c) Councillor Evans as Chair of the Procurement Advisory Board.

(5) That Councillor Childs be designated as Lead Member for Community Safety and Planning Policy; and

(6) That having received confirmation from the Police Authority that as a result of reviewing its political balance, the Council's second representative, who is a co-optee on the Authority, should come from the Conservative Group, that Councillor Simson be confirmed as the council's representative in place of Councillor Deane.

45 THE FOLLOWING NOTICES OF MOTION HAVE BEEN SUBMITTED BY MEMBERS FOR CONSIDERATION:

(1) FUR FREE CITY

45.1 The Notice of Motion as listed in the agenda was proposed by Councillor Fowler on behalf of the Labour Group. Councillor Fowler noted that fur farming had been banned by the Parliament Act 2000 and yet the fashion continued as the practice was allowed to operate in other countries and imports of goods meant it was difficult for consumers to differentiate between real and fake fur products. She was aware that many cities around the world had taken action to ban fur and councils has amended street trading licences to prevent the sale of fur. She hoped that councillors would support the motion and enable the council to take a lead on this issue and hopefully achieve a total ban.

45.2 The Mayor noted that it was Councillor Fowler's maiden speech and congratulated her on behalf of the council.

45.3 Councillor Evans formally seconded the motion and stated that the use of fur had become an important consideration for people and they wanted clearer labelling and for retailers to stop miss-selling goods. It was an important issue and Brighton and Hove should be a fur free city.

45.4 Councillor O'Quinn supported the motion and noted that the EU had the largest fur farms producing 50% of the global trade. She believed that fur looked better on live animals and hoped that the motion would be supported.

45.5 Councillor Druitt welcomed the motion and questioned why the importing of fur was still permitted as it made no sense. He believed it was important for the council to support the principle and ensure that it controlled what was available on its own land and in its properties and any change of policy to enable that should be supported.

45.6 Councillor Miller stated that he supported the intention to protect animals but questioned how the objective of the motion could be achieved and enforced. It would be difficult to take action against local businesses and to ensure that products were not being mislabelled.

45.7 Councillor Fowler thanked everyone for their comments and the support for the aims of the motion and hoped that animal welfare standards could be improved by taking action and making a positive stand against this trade.

45.8 The Mayor then put the following motion to the vote:

This Council resolves to request the Policy & Resources Committee:

- To consider the introduction of a policy to prohibit the sale of any product wholly or partially made with real animal fur on Council owned land and at Council run or Council leased markets. This ban to cover such items as fur coats, vintage fur, fur shawls, garments with fur trim, fur pompom hats, and fur accessories and trinkets.
- To explore the viability of extending said policy to the sale of leather.
- To support the Fur Free Markets campaign of the animal welfare charity, Respect for Animals, the UK's leading anti-fur organisation, by:
  a) Becoming a signatory to the initiative; and
  b) Seeking the advice and assistance of the charity in the enforcement of this ban.

45.9 The Mayor confirmed that the motion had been carried unanimously.

(2) HOUSING BENEFIT

45.10 The Notice of Motion as listed in the agenda was proposed by Councillor Williams on behalf of the Labour Group. She stated that housing benefit failed to keep in touch with the increases in private rents which meant that people either had to cut back on other essentials or get into debt. She hoped that the motion would be supported.

45.11 Councillor Evans formally seconded the motion and stated that the situation was only the top of the ice-berg. People were faced with living in sub-standard accommodation with increasing rent levels and other factors such as the gig-economy and zero-hour contracts having an impact on their ability to afford the rents. There was a need to find ways to support people and she hoped that the motion would be supported.

45.12 Councillor Gibson moved an amendment on behalf of the Green Group and stated that it sought to strengthen the motion and to look at what could be done locally to assist people by finding the means to provide housing for them and to support low income households.

45.13 Councillor Hugh-Jones formally seconded the amendment and noted that there was a reliance on the Government to make changes but felt that things could be done locally to improve the situation.

45.14 Councillor Platts stated that the Administration intended to have a report on how to support low income households and those facing increasing pressures of debt and hoped that this could be built into the budget process and supported by all Members.

45.15 Councillor Grimshaw stated that she fully supported the motion and the amendment and noted that she had experienced the situation and was faced with decisions about

how to meet her living costs. Thankfully, she had been able to access her pension recently which meant she was able to meet her rent bills for another year.

45.16 Councillor Mears stated that the Conservative Group would not support the motion but were happy to support the amendment. She also noted that where there was an increase in housing benefit, private landlords tended to then increase the rent levels. There was also a lack of affordable council housing which needed to be addressed so that those on housing benefit could afford the rent.

45.17 Councillor Williams noted the comments and confirmed she was happy to accept the amendment.

45.18 The Mayor noted that the amendment had been accepted and put the following motion as amended to the vote:

This council resolves to:

(1) Request the Policy & Resources Committee to take into account the need to reduce the burden on the poorest households in the city by making the council tax reduction scheme more generous and/or increasing funds available for discretionary support as part of this year's budget process, thereby easing pressure on low-income households facing high housing costs; and

(2) Ask the Chief Executive to write to the Secretary of State for Communities;

- Expressing the council's concern about local people being priced out of private sector housing at a time where there is insufficient social housing available; and
- Demanding that Housing Benefit levels are increased to an appropriate level.

45.19 The Mayor confirmed that the motion had been agreed unanimously.

(3) SCHOOL TRANSPORT POLICY PANEL

45.20 Note: The item was taken as part of the consideration of Item No. 37(1) Deputation concerning Home to School Transport and is detailed under that item (paragraphs 37.6-37.20).

(4) VALLEY GARDENS

45.21 Note: The item was taken as part of the consideration of Item No. 37(3) Deputation concerning Valley Gardens and is detailed under that item (paragraphs 37.21-37.38).

Closure Motion

45.22 The Mayor noted that the meeting had been in session for 4 hours and in accordance with council procedural rules, she was required to move a closure motion. She therefore moved that the meeting should be concluded and put the motion to the vote was unanimously opposed.

45.23 The Mayor noted that the motion had been lost and therefore invited Councillor Heley to move the next motion.

(5) GREEN NEW DEAL

45.24 The Notice of Motion as listed in the agenda was proposed by Councillor Heley on behalf of the Green Group. She stated that the country was facing a climate emergency and the council was not acting quickly enough. There was a need to restructure the economy and society to address the issue and enable the creation of new jobs in the low carbon industry if the target of being a net zero city by 2030 was to be achieved. The importance of the Green New Deal was now recognised and had to be supported and taken forward with partner agencies to prevent the catastrophe that would result if no action was taken.

45.25 Councillor Hills formally seconded the motion and stated that there was a clear need to put the climate first and take necessary actions to protect it and to deliver environmental change.

45.26 Councillor Platts moved an amendment on behalf of the Labour Group and stated that she hoped all the Groups could work together to ensure that action could be implemented locally to make a change. She believed the amendment strengthened the motion and that it could be supported.

45.27 Councillor Evans formally seconded the amendment and stated that it was an issue that was close to her heart and she hoped that a way forward could be achieved to address the issue.

45.28 Councillor Nemeth stated that he shared the concerns raised over climate change but was not as clear about the Green New Deal as there appeared to be a number of different interpretations. However, he hoped that there could be constructive discussions locally and an action plan agreed that could be taken forward.

45.29 Councillor Miller welcomed the motion and stated that there was a need to consider what actions could be taken forward and how the ambitions of the Green New Deal could be achieved.

45.30 Councillor Heley noted the comments and confirmed that she was happy to accept the amendment.

45.31 The Mayor noted that the amendment had been accepted and therefore put the following motion as amended to the vote:

This council resolves to declare:

- support for a ‘Green New Deal,’ as a policy framework that seeks to address climate change in ways that also: boost jobs, address poverty and inequality, and restructure our economic system;

This Council asks:

- For the Chief Executive to write to the Secretary of State and the Chancellor seeking their support for a Green New Deal and requesting an allocation of funding and resources to implement this locally

- For the Chief Executive to write to the Shadow Secretary of State and Shadow Chancellor, expressing our support for a Green New Deal.

This Council further requests that Policy & Resources Committee commission a report detailing how, alongside existing work: [1]

- poverty, inequality and accessibility can be addressed through the council's plan to become net carbon neutral ('net zero') by 2030;
- the council can work with partners (e.g.: Greater Brighton Economic Board, Chamber of Commerce) and specifically through the Local Enterprise Partnership, Coast2Capital, with particular reference to the Local Industrial Strategy and regional collaboration to lobby government for a stimulus package for low-carbon, 'green' jobs and decarbonisation projects; [2]
- the council can demonstrate good practice as a major employer by developing net-zero initiatives and employment opportunities;
- council can optimise the green credentials of council-owned buildings and public transport.

45.32 The Mayor confirmed that the motion had been carried unanimously.

45.33 **(6) SAFE SCHOOL WALKING ZONES**

45.34 Note: The item was taken as part of the consideration of Item No. 38(2) Petition for debate concerning School Walking Zones and is detailed under that item (paragraphs 38.13-38.30).

46 CLOSE OF MEETING

46.1 The Mayor thanked everyone for attending and closed the meeting.

The meeting concluded at 9.21pm

Signed Chair

Dated this day of 2019

Subject:	**Rejection of the usage of the terms 'Duke and Duchess of Sussex'- Petition for Debate**		
Date of Meeting:	**19 December 2019**		
Report of:	**Executive Lead Officer for Strategy, Governance & Law**		
Contact Officer:	**Name:**	Mark Wall	Tel: 01273 291006
	E-mail:	mark.wall@brighton-hove.gov.uk	
Wards Affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Under the Council's Petition Scheme if a petition contains more than 1,250 signatures and is not petition requesting officer evidence, it will be debated by the Full Council.

1.2 The e-petition has resulted in triggering a debate at the council meeting, having exceeded the threshold with a total of 3,696 signatures confirmed at the time of printing the report.

2. RECOMMENDATIONS:

2.1 That the petition is noted the council determine whether any other action is required.

3. RELEVANT BACKGROUND INFORMATION / CHRONOLOGY OF KEY EVENTS:

3.1 **The Petition**

Rejection of the usage of the terms 'Duke and Duchess of Sussex'
Lead Petitioner – Charles Ross

Additional Information:

We the undersigned petition Brighton & Hove Council to reject the usage of the titles "Duke of Sussex" and "Duchess of Sussex" by the individuals Henry ("Harry") Windsor and Rachel Meghan Markle as morally wrong and disrespectful to the county of East Sussex. As residents of Brighton and Hove we call on Brighton and Hove Council to not refer to these individuals by such titles which we believe to be entirely non-democratic and symbolic of the oppression of the general public by the wealthy elite. Neither will Brighton Council invite or entertain these individuals nor afford them any hospitality or courtesies above and beyond that of an ordinary member of the public.

The petition aims to establish a precedent that Brighton and Hove Council will no longer afford official hospitality to those with Royal or aristocratic titles nor make usage of those titles in official documents as these titles are arbitrarily and unfairly acquired.

4. PROCEDURE:

4.1 The petition will be debated at the Council meeting in accordance with the agreed protocol:

(i) The Lead petitioner will be invited by the Mayor to present the petition and will have up to 3 minutes in which to outline the prayer of the petition and confirm the number of signatures;

(ii) The Mayor will then open the matter up for debate by councillors for period of 15 minutes and will first call on the relevant Committee Chair to respond to the petition and move a proposed response. The Mayor will then call on those councillors who have indicated a desire to speak in the matter, before calling on the relevant Committee Chair to respond to the debate;

(iii) An amendment to the recommendation in paragraph 2.1 of the report or to add additional recommendations should be submitted by 10.00am on the day of the meeting; otherwise it will be subject to the Chair's discretion as to being appropriate. Any such amendment will need to be formally moved and seconded at the meeting;

(iv) After the 15 minutes set aside for the debate, the Mayor will then formally put:

(v) (a) Any amendments in the order in which they are moved, and

(b) The substantive recommendation(s) as amended (if amended).

WRITTEN QUESTIONS FROM COUNCILLORS

The following questions have been received from Councillors and will be taken as read along with the written answer which will be included in an addendum that will be circulated at the meeting:

(1) Councillor West - Resident Parking Permit surcharges

What additional administrative cost is incurred from offering quarterly or half yearly residents parking permits? Given digital transaction costs are low, is the current and proposed surcharge justifiable? Low income households can experience cash flow difficulties which prevent their paying upfront for longer permit periods. Will the Budget proposal ensure the surcharge is minimised and only covers justifiable cost?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(2) Councillor West - Business Parking Permit Surcharges

Is the proposed 15% surcharge on quarterly business parking permits, over and above the proposed annual charge, justifiable on the basis of additional administrative cost?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(3) Councillor West - Budget readiness for carbon neutrality

Transport makes up over a quarter of the city's carbon footprint, much of which relates to the use of the city's 100,000 private cars. Private car use needs to be reduced to help tackle air pollution, congestion and road danger in the city; freeing space and supporting more people to travel actively on foot and bike or by public transport. The Council has declared a climate emergency and is committed to the city becoming carbon neutral by 2030. Parking charges are a strong lever the council is able to use to encourage less car use. The Administration's draft budget proposes to raise income from parking charges by a very modest amount, is that sufficient? Will the budget as a whole show strong ambition in readying the city for carbon neutrality?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(4) Councillor West - Park and Ride and "EV Car Revolution"

Meeting the challenges of climate change requires bold, community-focused change. So, I am concerned the Chair of ETS is intent on including consideration of Park and Ride in LTP5. Park and Ride is not a solution, it merely shifts toxic car emissions from one part of our city to another – it will not

cut congestion, reduce air pollution or make the option to travel by bike or on foot safer and more attractive. It's also difficult and costly to implement. For decades successive Labour and Council councils have promised Brighton & Hove voters Park and Ride, yet never delivered it. Despite this truth, the Labour Party just can't let go of their fantasy of a 'big solution'. Just last week, we also read the Leader of the Council, Nancy Platts, stating that an 'electric car revolution' is on its way. Emissions from transport equates to more than a quarter of our local carbon footprint, with personal car travel a big contributor. There are 100,000 cars in the city, can that continue? Will changing them all for electric cars make much difference? Given the investment that would be required in electricity generation, transmission and charging infrastructure, as well as the high level of energy embodied in making the vehicles, the answer is probably no. We must acknowledge for many, cars are still the only accessible mode of transport – but that an RAC survey found that people would ditch the car, if public transport was cheaper and more available.

Let's be clear: piecemeal solutions will not meet the challenge of climate crisis. If we agree there is an emergency, we need to shift our conversations towards supporting people to make positive changes. Whether it's pushing for action on dirty air pollution, a boost to public transport, walking and cycling, or a Green New Deal to create jobs in renewable energy sectors, there are important and ambitious ways to create a positive change. We need our leaders to grasp the scale of the problem and lead the way on city-wide solutions – not put all their energy into promoting ineffective sticking plasters.

Will the Chair of ETS make clear that Park & Ride will not aid realising carbon neutrality by 2030, and therefore will not be progressed in LTP5?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee.

(5) Councillor Heley

At the last full council meeting I was delighted that the Green New Deal Motion that myself and Cllr Hills proposed received unanimous, cross-party support. Will the Leader of the Council provide an update on the Green New Deal report that was requested in the motion, including details on:

- If any stakeholders are involved
- Who the lead officers are that have been assigned to this report
- What the proposed timescale is
- When the city can expect to see the final version.

Reply from Councillor Platts, Leader of the Council.

(6) Councillor Heley

Does the Administration have any plans to change existing emissions-based tariffs for residents parking permits, e.g. to expand beyond the 2 tiers of high and low emission vehicles? In order to tackle air pollution and to incentivise use of low emission vehicles, it would be good to have a further breakdown of emission levels with more being charged for higher emitting vehicles?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee.

(7) Councillor Ebel

Can you please give us an update on how many of the Non-British EU citizens in Brighton & Hove

a) have applied for Settled Status so far
b) have been granted Settled Status so far
c) have been granted Pre-Settled Status so far
d) have not yet applied for Settled Status
e) have used the service in Brighton Town Hall to scan their ID and documents to apply for Settled Status

The New European and other newspapers recently revealed that the Android app that is used to apply for Settled Status can be easily hacked and that sensitive information, such as passport information, passwords and facial scans can be stolen without circumstance. Can you please confirm that the scanners provided by the Council in Brighton Town Hall have been checked following these revelations and that the security flaws do not affect the scanners?

Reply from Councillor Platts, Leader of the Council.

(8) Councillor Rainey - Single-use plastics

Efforts to make Brighton and Hove single-use plastic free have been going on since 2017 when a petition and Notice of Motion from the Green Party, calling for the city to pledge to become plastic free, were passed at full council. Many of the city's large events, and a number of businesses, have now committed to phasing out single-use plastics and earlier this year a campaign was launched for Brighton to achieve Plastic Free Community status.

This autumn Penzance was declared the UK's first town to achieve Plastic Free Community status. This status involves the council eliminating all single use items from their premises and supporting Plastic Free Community initiatives across the town. In Penzance local businesses and communities have been engaged with, and 12 local schools have become plastic free.

Brighton and Hove has the ability to become the first city in the UK to be awarded Plastic Free Community status, and we have already committed to becoming plastic free. However single-use plastic is still being used by many businesses, communities and schools across the city. Please can we have an update on what has been successfully done so far, and when we expect to achieve plastic free status?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(9) Councillor Clare

Amendments passed in the 2019-20 budget included £0.022m for City Clean to support Universities with a recycling project to minimise fly-tipping at the end of term. How has this been used?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(10) Councillor Clare

Could you supply me with the proportion of CTR recipients in council tax arrears per year from 2015-2019?

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

(11) Councillor Clare

What proportion of events in the city have incurred fines for the state of land at the end of events and of these, are any on Hove Lawns?

Reply from Councillor Robins, Chair of the Tourism, Equalities, Communities & Culture Committee

(12) Councillor Hugh-Jones

Since 1 April 2018, private landlords are no longer permitted to let domestic properties on new tenancies to new or existing tenants if the property's Energy Efficiency Certificate rating is F or G (unless an exemption applies). From 1 April 2020, this exemption will apply to all such properties even where there is no change in tenancy.

Enforcement is a matter for the local authority. Local authorities may serve compliance notices up to 12 months after a suspected breach has occurred. Where a local authority confirms that a property is (or has been) let in breach of the Regulations, it may impose a financial penalty up to 18 months after the breach and/or publish details of the breach for at least 12 months. By way of example, penalties for renting out a non-compliant property for 3 months or more are up to £4000 per property.

In light of the above, what steps is the Council taking to prepare to enforce EPC ratings in the private rental sector after April?

Reply from Councillor Williams, Chair of the Housing Committee

(13) Councillor Fishleigh

The i360 says that it will contribute £640million to the local economy over the next 25 years which amounts to £70,000 a day every day, can you give us a breakdown of this figure in terms of financial benefits to hotels and other accommodation, restaurants, cafes and bars, car parks, independent shops and other tourist attractions?

Reply from Councillor Robins, Chair of the Tourism, Equalities, Communities & Culture Committee

(14) Councillor Hills

Following the motion put forward by Councillor Amy Heley at the last full council meeting, we've agreed as a council to work towards a Green New Deal policy framework, which means restructuring our economy to work towards eliminating carbon emissions and increasing biodiversity, while boosting local jobs. To do this effectively, we will need to train a high number of workers in a range of skills.

- I'd like to ask the leader of the council if the skills and specialisms needed for this transition have been identified and if so, could this made public?
- What will the council do to make sure that we can recruit enough local people to take up these roles?
- What work is currently being done to ensure local colleges, training providers and employers can provide effective training for these new positions?

Reply from Councillor Platts, Leader of the Council

(15) Councillor Nield

Varndean School has recently sent out plans to local residents showing its proposed expansion. Residents are concerned about the effects on local traffic of an increase in pupil numbers. There have already been serious accidents involving pupils on both Ditchling Road and Preston Drove, and parking at the top of Balfour Road at school pick up and drop off times can already be dangerous and chaotic.

Residents would like to know what plans the council has to mitigate the repercussions of increased pupil numbers on traffic and parking around the school, and what plans they have to improve the safety of those pupils who walk and cycle to both Varndean and the other schools which share the grounds of the Surrenden campus.

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(16) Councillor Hugh-Jones

When Boots and the Coop closed on London Road in preparation for the redevelopment of that site, it was anticipated that Boots would move across the road. There have since been reports that this has fallen through. Will the Health and Wellbeing Board be raising this serious failure of provision to local residents, particularly as this relates to prescription services?

Reply from Councillor Moonan, Chair of the Health & Wellbeing Board

(17) Councillor Hugh-Jones

Also, on the subject of London Road, where can residents find information about the proposed redevelopment? The information on the Council's website appears to date from 2013.

Reply from Councillor Robins, Chair of the Tourism, Equalities, Communities & Culture Committee

(18) Councillor Mac Cafferty

Can you please tabulate the quantity of complaints about licensed premises for each street in Brunswick and Adelaide Ward per year in the past five years? In 2019 which licensed premises and the corresponding street; in 2018 which licensed premises and the corresponding street; in 2017 which licensed premises and the corresponding street; in 2016 which licensed premises and the corresponding street; in 2015 which licensed premises and the corresponding street.

Reply from Councillor O'Quinn, Chair of the Licensing Committee

(19) Councillor Mac Cafferty

Can you please tabulate the quantity of fixed penalty notices for environmental offences of littering, littering from vehicles, dog fouling, graffiti, fly posting, unauthorised flyering, industrial and commercial waste receptacle offence, residential fly tipping, commercial fly tipping, disposing of commercial waste illegally, failure of business to produce a waste transfer note per year from March 2016 to December 2019. In 2016, how many FPNs and for which offence; in 2017 how many FPNs and for which offence; in 2018 how many FPNs and for which offence; in 2019 how many FPNs and for which offence. The last time I asked this question I was informed that the council didn't have data before March 2016, why is that given that we have had FPNs since the 1990 Environmental Protection Act.

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(20) Councillor Mac Cafferty

As records have been kept only by ward since 2018/19, can you please tabulate new reports of, or enquiries regarding, ASB for each street in Brunswick and Adelaide Ward per month. This would mean each street will have a clear record of reports for each month for this period. As reports weren't kept per ward what was recorded prior to this, and how do I understand what incidents, reports or enquiries happened on the streets in my ward before this point?

Reply from Councillor Childs, Lead Member for Community Safety

(21) Councillor Mac Cafferty

At last full council I tried to ask questions about:

(1) the quantity of complaints about communal bin collections;
(2) the quantity of complaints about the state of communal bins and;
(3) the age of each communal bin,

on each street in Brunswick and Adelaide Ward for the past five years?
But was told that this information is not available as complaints have not been recorded in this way. As the area of the city where communal recycling was trialled in 2012 and as one of the first areas of the city with some of the oldest communal waste bins how am I to understand now, not after the audit, how the council understands

(1) the quantity of complaints about communal bin collections;
(2) the quantity of complaints about the state of communal bins and;
(3) the age of each communal bin. Especially as the city does record quantities of missed collections for recycling and this is captured in the KPIs report.

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(22) Councillor Gibson

Please provide a table showing the additional council homes provided for each year (or part year) 2015/16 through until the part year 2019/20 up till December 15th and for each year (or part year) show the additional annual rent income receivable for these homes at today's rents?

Reply from Councillor Williams, Chair of the Housing Committee

(23) Councillor Gibson

For the home purchase policies operation up until December 15th 2019, please can you provide:

- the number of homes on which a purchase has been completed and of the number used as temporary and as general needs?

- A breakdown of the numbers charging social rents, 27.5% Living wage, 37.5% Living wage and Local housing allowance?

- A breakdown of the number of properties coming from the "first refusal" option when RTB homes are sold on and the numbers coming from other routes?

Reply from Councillor Williams, Chair of the Housing Committee

(24) Councillor Gibson

Please can you explain the “anomaly” experienced with the DWP indicating how this is hampering the councils collection of rent on behalf of seaside homes and when it is anticipated that this anomaly will be resolved (also some details on how the collection procedures are being reviewed and what (if any) changes are being implemented to improve on the 85.6 % collection rate reported to P&R)? (see answers to P&R – 5th December)

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

(25) Councillor Gibson

Of the borrowing taken out at 2.17% (average rate) what percentage of the assumed borrowing was actually taken up? (see written answers to P&R on 5th on December)

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

(26) Councillor Gibson

As of 15th December, how much of the £1m rent reserve created in the 2019/20 budget to support social rents and 27.5% Living wage rents has been spent, and how many additional homes at social rents and 27.5% living wage (living) rents is it projected will be supported during the rest of the current financial year?

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

(27) Councillor Gibson

What is the proposed (2020/21) CPZ permit increase per week for a full scheme permit and the proposed cost of “surcharge” per week on each of 2nd and 3rd permits?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(28) Councillor Gibson

As of December 15th, 2019;

- How many council homes have been sold under the RTB during this financial year?

- What is the current level HRA borrowing and how much is this under the previous borrowing cap?

Reply from Councillor Williams, Chair of the Housing Committee

(29) Councillor Osborne - Possibilities to claim extra support and how the Administration is encouraging this

With the complicated means-tested benefit system that we have in the UK there are millions of people each year that don't realise that they are due extra support and fail to claim. As a result, there is extra demand placed on council run services.

1. What extra support is available for residents to apply for in terms of benefits, tax relief etc both from the council and nationally?
2. What are the take-up rates of these various possible support schemes in terms of number of eligible people vs actual number of claimants (in Brighton and Hove)? How does this compare with other local authorities?
3. Are these figures regularly tracked to see if there are any trends emerging?
4. What actions are the administration currently taking to promote the availability of these schemes and how are they supporting people when applying?
5. Are there any further plans to support people when applying in the future and to help to increase their uptake?

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

(30) Councillor Osborne - Universal Credit

The national government embarked on an overhaul of the welfare system when they started the transition towards universal credit. There have been several delays in the roll out of this but how far through the roll out are we as of December 2019 in terms of the % of claimants who now receive universal credit? When do we expect all claimants to be moved onto this system?

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

(31) Councillor Powell – Tree Planting

In July 2019, the BBC reported that "*Ethiopia has planted more than 350 million trees in a day, officials say, in what they believe is a world record."*

How many trees were felled by BHCC in the last year? And how many trees were planted in the last year by BHCC? Crucially, what plan has this labour administration committed to (along with ideas such as Plant Your Postcode) to plant even more trees in the next few years, now that our council has declared a climate emergency?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(32) Councillor Powell

Since the eligibility age for concessionary bus fares is set to rise to the age of 66 by October 2020, can the ETS Chair please confirm if this has in fact, already been actioned by BHCC? And if not, when?

And importantly, what specifically will the surplus income be used for, going forward? Could Companion Passes for those residents accompanying disabled passengers be an option, as in other authorities? As currently, BHCC do not offer these.

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(33) Councillor Powell – Blue Badges

BBC in June 2019 reported: "*About 2.35 million people in the UK have blue badge permits because of physical mobility difficulties or are registered blind. People with hidden disabilities are now also being considered as the change came into force on 30 August 2019. Scotland and Wales have already implemented similar rules to include some mental health impairments, (but the criteria is yet to be altered in Northern Ireland). The government said it would provide an extra £1.7m to help councils cope with the expected increase in applications".*

Has BHCC advertised this change, and informed Service users and community groups (as I am not aware of any such publicity)? And have they seen such applications increase? If not, will BHCC look into this matter forthwith?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(34) Councillor Druitt

Recently a small number of councillors from Labour & Green parties visited Tablehurst Farm in Forest Row and experienced what sustainable community farming looks like. By its own admission it was not a perfect example, rather they were 'on a journey'. However, they haven't used pesticides or herbicides for over 40 years; the quality of their soil and their biodiversity is outstanding; and the level of employment, community engagement and educational opportunity is second to none.

Bearing in mind most of our city's water comes directly from our own downland estate and currently the (untreated) water quality in the city is amongst the worst in the whole South Downs, isn't it high time we stopped allowing herbicides and pesticides on our land and managed the transition to sustainable, community farming practices that do not pollute the environment,

have a much lower carbon footprint and offer far more in terms of employment, community engagement and education?

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

ORAL QUESTIONS FROM COUNCILLORS

A period of not more than 30 minutes is set aside for oral questions from Members, at the expiry of which, the Mayor will call a halt and proceed to the next item of business of the agenda. Any Member whose question then remains outstanding will be contacted to determine whether they wish to have a written answer provided or for their question to be carried over to the next meeting.

The following Members have indicated that they wish to put questions to the Leader, Chairs of Committees or Members of the Council that have been appointed to an outside body. The Councillor asking the question may then ask one relevant supplementary question which shall be put and answered without discussion:

(1) Councillor Mac Cafferty
Subject matter: Our City Centre

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(2) Councillor Bell
Subject matter: Cross-Party Working

Reply from Councillor Platts, Leader of the Council

(3) Councillor Clare
Subject matter: School Improvement

Reply from Councillor Allcock, Chair of the Children, Young People & Skills Committee

(4) Councillor Theobald
Subject matter: Pavements & Graffiti

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(5) Councillor Fishleigh
Subject matter: Lottery Funding for Madeira Terraces

Reply from Councillor Robins, Tourism, Equalities, Communities & Culture Committee

(6) Councillor Janio
Subject matter: Democracy in Brighton and Hove

Reply from Councillor Platts, Leader of the Council

(7) Councillor Deane
Subject matter: Tell Us Once

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

(8) Councillor Nemeth
Subject matter: King Alfred

Reply from Councillor Platts, Leader of the Council

(9) Councillor Shanks
Subject matter: Pavement Parking

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(10) Councillor Wares
Subject matter: Home to School Transport

Reply from Councillor Allcock, Chair of the Children, Young People & Skills Committee

(11) Councillor Hills
Subject matter: Voluntary Payments to the Council

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

(12) Councillor Rainey
Subject matter: Brighton Youth Centre

Brighton Youth Centre is a much-loved institution in Queens Park ward, however it is in dire need of rebuilding. The centre offers a mix of activities and projects for all young people including young carers, young offenders, young parents, homeless young people and young people with disabilities. Please can we have confirmation of the council support for the rebuild of the centre, and assurance that the capital investment and revenue required will be forthcoming, securing the proposed matched investment from Onside?

Reply from Councillor Allcock, Chair of the Children, Young People & Skills Committee

(13) Councillor Ebel
Subject matter: Brexit

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

(14) Councillor Heley
Subject matter: Recycling

Reply from Councillor Pissaridou, Chair of the Environment, Transport & Sustainability Committee

(15) Councillor Hugh-Jones
Subject matter: Equality Impact Assessments

Reply from Councillor Grimshaw, Lead Member for Equalities

(16) Councillor Gibson
Subject matter: Budget Commitments to Achieve Council Priorities

Reply from Councillor Yates, Deputy Chair (Finance) of the Policy & Resources Committee

(17) Councillor Powell
Subject matter: Equalities

Reply from Councillor Grimshaw, Lead Member for Equalities

(18) Councillor Druitt
Subject matter: Progress Towards a Net-Zero Economy in the City

Reply from Councillor Platts, Leader of the Council

Council	Agenda Item 57
19 December 2019	Brighton & Hove City Council

Subject:		**Corporate Plan 202-2023 –** Extract from the proceedings of the Policy & Resources Committee meeting held on the 5 December 2010
Date of Meeting:		**19 December 2019**
Report of:		**Executive Lead Strategy Governance & Law**
Contact Officer:	Name:	**Lisa Johnson** **Tel: 01273 291228**
	E-mail:	lisa.johnson@brighton-hove.gov.uk
Wards Affected:	All	

FOR GENERAL RELEASE

Action Required of the Council:
To receive the item referred from the Policy & Resources Committee for approval:
Recommendation:
That Full Council approve the draft Corporate Plan 2020-2023

BRIGHTON & HOVE CITY COUNCIL

POLICY & RESOURCES COMMITTEE

4.00pm 5 DECEMBER 2019

BRIGHTON TOWN HALL - COUNCIL CHAMBER

MINUTES

Present: Councillors: Platts (Chair), Yates (Deputy Chair), Mac Cafferty (Opposition Spokesperson), Mears (Group Spokesperson), Allcock, Clare, Gibson, Moonan, Shanks and Simson

MINUTE EXTRACT

PART ONE

87 CORPORATE PLAN 2020-2023

87.1 The Committee considered the report of the Executive Lead Strategy Governance & Law regarding the draft Corporate Plan 2020-23 which is part of the Council's Policy Framework.

87.2 The Chief Executive said that the current Corporate Plan ran out in March 2019 and so it was time for a new one to be produced. It was important for any organisation to have a plan to reflect any changes in the world, and the needs and expectations of residents and service users. In May 2019 we had local elections and a result half of the current Councillors are new, and they have brought in fresh thinking and new ambitions and the plan reflected their views. The Council surveyed staff on a regular basis and one of the things that had come out of that was that they wanted clear direction from the leadership, and it was important that they understood what the Council would do. A Corporate Plan is also welcomed by stakeholders in the city and partners the Authority worked with to understand what the priorities were.

87.3 Councillor Gibson welcomed the Plan but suggested that some of the actions could be more specific and measurable. He referred to page 26 of the Plan and the section on Measuring Progress and said it would be useful to signpost the fact that progress on the housing goals would be reported to every other Housing Committee meeting. He referred to page 9 of the Plan and noted that it said that there were '197 newly developed rented council homes with 500 more in the pipeline', but it didn't say how long that had taken and he suggested that the Plan could be clearer on timescales and to say how many homes there were per year and over what period of time. The same page also said that the Council had 'helped bring 125 properties back into use between April and December 2018' and he thought that it would be better to give the amount for the year.

87.4 Councillor Allcock welcomed the Plan which showed the corporate direction and met the three big challenges which were the climate emergency, homelessness and the need to

build community wealth. It set out the six long term outcomes which the Council wanted to focus on. He said that the Plan had been developed with the Green Group and reflected key aspects of both group's manifestos and what people in the City wanted. The Plan set out the Council's priorities and direction of travel for the next three years and was a key part of the Council's budget. Officers would be working on key performance indicators, and progress would be monitored by the relevant committees.

87.5 RESOLVED: That the Committee approves the draft corporate plan 2020-2023 for submission to full Council for final agreement on 19 December 2019.

Council	Agenda Item 57
19 December 2019	Brighton & Hove City Council

Subject:		**Corporate plan 2020-2023**
Date of Meeting:		**19 December 2019** 5 December 2019 - Policy & Resources Committee
Report of:		**Executive Lead Officer for Strategy, Governance & Law (Monitoring Officer)**
Contact Officer:	**Name:**	**Simon Newell**
	Email:	**simon.newell@brighton-hove.gov.uk**
Ward(s) affected:		**(All Wards);**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The corporate plan 2020-23 is part of the council's policy framework. The plan provides the overall direction for the council over the coming three years. It describes the outcomes the council aims to achieve for the city. It sets out at a high level how the council intends to deliver those outcomes. The plan also drives business planning for the council with detailed delivery plans set out in directorate and service plans. Monitoring of progress is through the council's performance framework which is regularly reported to the Policy & Resources Committee.

1.2 The draft corporate plan 2020-23 is included at appendix 1 of this report.

2. RECOMMENDATIONS:

2.1 That the Committee approves the draft corporate plan 2020-2023 for submission to full Council for final agreement on 19 December 2019.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The plan sets out six intended outcomes. These are:

- A city to call home
- A city working for all
- A stronger city
- A growing and learning city
- A sustainable city
- A healthy and caring city

3.2 For each outcome commitments and actions have been grouped into five themes.

3.3 In addition three priority areas for additional focus have been identified. These are:

- Carbon neutral by 2030

- Housing, homelessness and rough sleeping
- Build community wealth, so that local people and organisations benefit from prosperity in the city.

3.4 Contextual information about the city's population and the council's services and spending is included in the introductory sections.

3.5 The final chapter covers enablers for successful delivery of the plan. These include the council's Customer Promise, the Fair and Inclusive Workplace Promise, work to modernise the way the council conducts its business and partnership working.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The corporate plan 2020-23 is part of the council's policy framework. Consideration of previous plans, earlier drafts and feedback from policy committee chairs has led a more concise plan with a clearer focus on city wide outcomes and priorities to give focus to the work of the organisation.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Priorities in the corporate plan have been discussed with partners and stakeholders and their feedback has been reflected in the draft plan.

6. CONCLUSION

6.1 The Committee are asked to agree the corporate plan for submission to full Council on 19 December 2019 for final approval.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The corporate plan 2020-23 should be considered in the context of preparing a new Medium Term Financial Strategy (MTFS) for the same period, and will consequently inform the budget setting process for 2020/21. Budget proposals will therefore reflect priorities where possible.

7.2 Given the potential for a change in government and also that the existing Spending Review period covers only 2020/21, the detail of any MTFS may have to wait until there is a clearer picture of the funding envelope for local government from 2021-22 onwards.

7.3 Monitoring progress against performance measures is a key element of the Performance and Risk Management Framework; any financial risks or resource requirements identified as a result will be considered in budget monitoring and in developing future years' budgets.

Finance Officer Consulted: David Kuenssberg Date: 05/11/19

Legal Implications:

7.4 The council's Constitution provides that the Policy & Resources Committee has responsibility for formulating the corporate plan, whereas formal approval of the final version is a matter reserved to full Council. The Corporate Plan forms part of the Council's policy framework, which means any decisions of Committees or officers need to be in consistent with the Plan. The adoption of the plan will help the Council is achieving a more coherent policy direction and more effective prioritisation of resources which, in turn, help the Council in complying with its best value duty under the Local Government Act 1999.

Lawyer Consulted: Abraham Ghebre-Ghiorghis Date: 7 November 2019

Equalities Implications:

7.5 The council is subject to the general equality duty set out in section 149 of the Equality Act 2010. This duty covers the following protected characteristics: age, gender, gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation.

7.6 In delivering the plan the council must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups

7.7 The draft corporate plan has been shared with the council's equalities manager and their comments have been reflected in the plan. Given the breadth of the corporate plan and the complexity of relevant protected characteristics and their intersections it is not possible to analyse all the impacts of the plan in relation to legally protected characteristics. However, the council's legal duties (Equality Act 2010) have shaped the development of the plan and inform its content, in relation to eliminating discrimination, advancing equality of opportunity and fostering good relations.

7.8 It is also recommended that specific initiatives set out in the plan require a more detailed Equalities Impact Assessment as part of the council's decision making process. Areas of investment identified in the corporate plan, as well as other decisions relating to implementation of the plan, will require Equality Impact Assessment as proposals are brought forward to relevant committees or Full Council.

Sustainability Implications:

7.9 Sustainability implications are set out across the plan with a particular focus given to sustainability in the chapter *A sustainable city*. The plan as a whole seeks to achieve a fairer city which has a sustainable future.

Any Other Significant Implications:

Crime and Disorder Implications

7.10 Crime and disorder implications are described in the corporate plan in the chapter *A stronger city.*

Risk and Opportunity Management Implications

7.11 Progress against delivery of the corporate plan will be monitored through the council's Performance and Risk Management Framework.

Public Health Implications

7.12 Public health implications are described in the corporate plan in the chapter *A healthy and caring city*. Other measures in the plan will have a direct impact on improving health and reducing health inequalities, for example, improving air quality and facilitating cycling and walking.

Corporate / Citywide Implications

7.13 The corporate plan sets out the outcomes that the council seeks to achieve for the city. These form the basis for work with partners and the wider community to achieve a fairer and more sustainable city.

SUPPORTING DOCUMENTATION

Appendices:

1. Draft corporate plan 2020-23

Documents in Members' Rooms

1. Hard copy of the draft corporate plan 2020-23

Background Documents

None



Brighton & Hove City Council

Our plan 2020 to 2023

A fairer city, a sustainable future

Brighton & Hove City Council

Contents

Introduction	3
Our city, your council	4
A fairer city with a sustainable future	10
A city to call home	12
A city working for all	16
A stronger city	18
A growing and learning city	20
A sustainable city	22
A healthy and caring city	24
How will the plan be delivered?	26



Introduction

I love our city and I'm proud to tell people where I live. Whenever I meet someone for the first time, they always ask me where I live and when I tell them, they never fail to smile. Everyone has heard of Brighton & Hove and everyone I meet tells me how lucky I am to live here.

I am lucky to live in Brighton & Hove but luck didn't bring me here.

I chose to live in Brighton & Hove. I wanted to live here because of this city's reputation. Its reputation for fun and freedom, for radicalism and rebelliousness, together with its strong sense of tradition and proud history. There's nothing in our city which says all of these things more than the world famous Royal Pavilion.

Every time I see the iconic domes, I'm reminded that meaningful reputations, ones which people really believe in, always come about as a result of actions, things we can see, and not just what someone or an organisation says.

And that's what this plan is about. It's not fanciful and impulsive; it's not aspirational words that once presented at a council meeting will never be seen again. This is a plan that's going to deliver real change across the city. Change that you told us you want to see happen and change that you voted for in May 2019.

This is a plan which clearly says what we're going to do and it's a plan you'll be able to hold us to account to. We've been working closely with our experienced and dedicated council staff who tell us everything in this plan can be delivered and I thank them for their support and their positivity.

There are three areas of change that huge numbers of you told us you want to see in the city and they are:

- **make our city carbon neutral by 2030**
- **improve access to good quality housing and reduce homelessness and rough sleeping**
- **build community wealth so that local people and organisations benefit from prosperity in the city**

Hearing these repeated to me time and time again by residents reminded me again why I choose to live in Brighton & Hove.

We are a city that cares. We are warm people, we throw our arms around others we don't yet know and we welcome them. We are creative and we're world leaders when it comes to technology. We want our city and the people who live here to thrive.

We help people who need it most. We support others to get back on their feet if they've had a bad time. We celebrate difference, we challenge inequality and we will never accept hatred and discrimination towards our diverse communities. We care about the kind of world future generations will live in. We are a City of Sanctuary.

This isn't a plan the council can deliver on our own. We all need to come together over the next three years and play a part in creating a fairer and sustainable city. This is an exciting time of change for us all. This plan will help you be part of it.



Councillor Nancy Platts
Leader, Brighton & Hove City Council

DRAFT

Our city, your council

Our city - who are we?

Knowing who lives in our city, the skills we have, how we're all feeling about where we live and the difficulties people might be facing means we can work better together with communities and organisations across Brighton & Hove to design and deliver the services people want, need and can use.

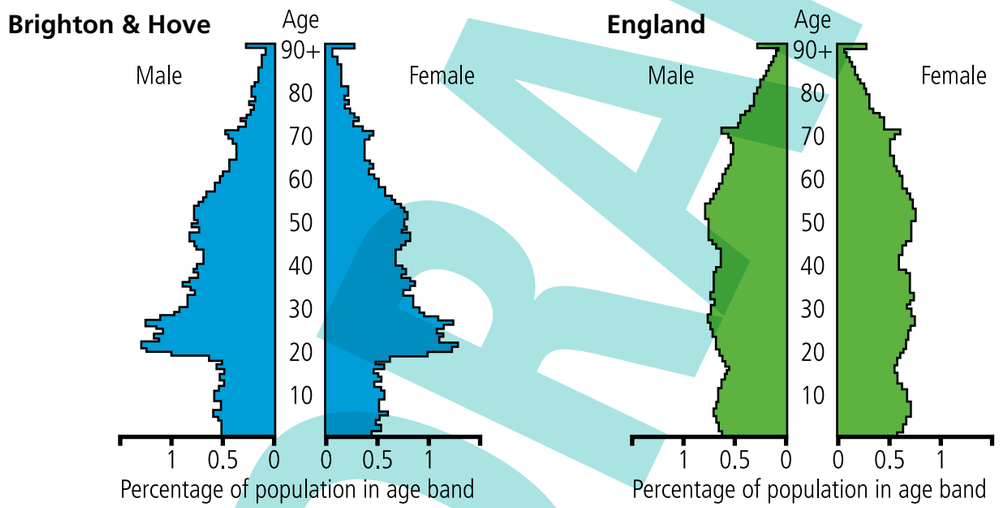
Knowing more earlier means we can reach out and support people. This also helps prevent more expensive interventions meaning public money can be spent on other much needed services.

Population

290,395 residents (2017)

21% under 20 (24% Eng)
62% 20 to 59 (53% Eng)
11% 60 to 74 (15% Eng)
6% 75+ (8% Eng)

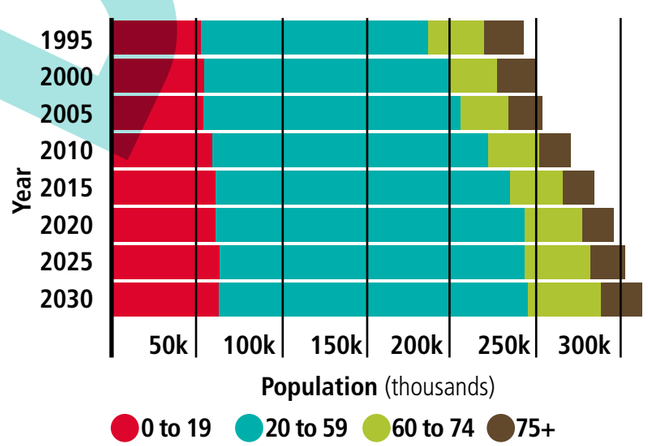
Our population profile is younger than England



Projections

There are projected to be **23,300 more people** living in the city by 2030 (compared with 2017, an 8% increase to 311,500 people).

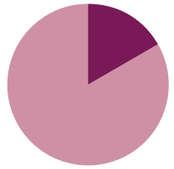
The city's population is predicted to get older, with the greatest projected increases in the 60 to 74 years (33%, 10,800 extra people) and 75+ age group (30%, 5,300 extra people). There are projected to be 700 more 85 to 89 year olds and 400 more 90+ year olds.



Population groups

Our city consists of different population groups living in a range of communities.

One in five people (19.5%) are from a Black or Minority Ethnic group (14.5% South East, 20.2% England).





49% of residents have a religion, lower than the South East (65%) and England (68%).

More than **one in 20** residents say their day to day activities are 'limited a lot' due to a long term health problem or being disabled.



Our best estimate of lesbian, gay and bisexual residents is 11% to 15% of the population aged 16+.



At least **2,760 trans adults** live in Brighton & Hove, with many more who visit to socialise, study or work.

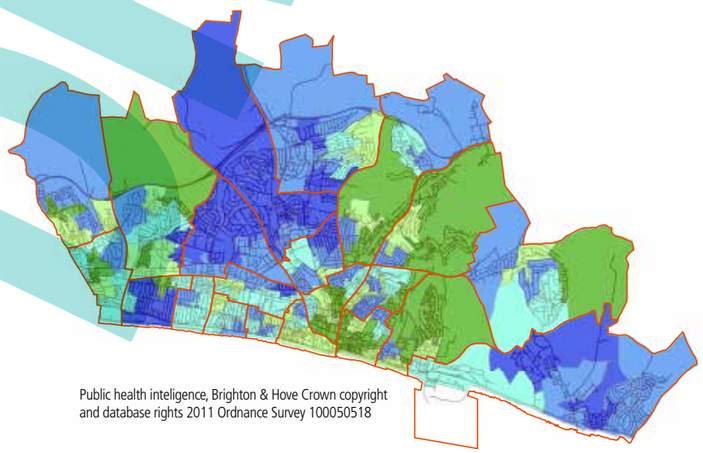


52,000 residents were born outside of the UK (18% of the city's population), higher than the South East (14%) and England (16%).

Deprivation

Our city is the **131st** most deprived local authority in England (of 317).

Indices of deprivation 2019
Index of multiple deprivation (IMD), ranked by score



Some areas are more affected by deprivation than others.

The highest concentration of deprivation is in the **Whitehawk, Moulsecoomb,** and **Hollingbury** areas. Along the coast, to the west of the city and in **Woodingdean,** there are also pockets of deprivation. All these areas are in the **20%** most deprived areas in England.

Your council

We're proud of our staff who deliver over 700 services for residents and visitors to the city. There aren't many organisations that conduct marriages, support people to leave hospital, shepherd sheep, look after a royal palace and maintain nearly 400 miles of roads, all in a normal working day.

Here's a snapshot of our recent work for the city

We are the corporate parent for **392** children in care & **328** care leavers

In 2018, Ofsted inspected our children's social care services and rated them 'good' Ofsted

Protecting **3,400** listed buildings forming our unique heritage

Performed citizenship ceremonies for **736** new British citizens

Celebrated **1,233** marriages or civil partnerships

Registered **3,094** births and **2,740** deaths

91% of schools being judged Good or Outstanding by Ofsted

Maintaining and cleaning **700** miles of pavements - that's the same as from Brighton to John O' Groats!

Managing **13km** of seafront from Saltdean to Hove Lagoon

Almost **5m** refuse collections and **2.5m** recycling collections a year

£962,422 worth of benefits re-instated in 2017/18 and 2018/19

250+ outdoor events with more than **1m** attendees a year

3x winner of the National Transport Local Authority of the Year

We have **15** social work teams working with **1,961** children in need through a whole family approach

38km of designated cycle routes

Jubilee Library is the fifth most popular library in the country with **932,994** visits a year

Helped bring **162** empty properties back into use in 2018/19

In 2018, seafront lifeguards saved **24 lives**

717 households prevented from becoming homeless in 2018/19

Generated **£11.5m** over the last 4 years to invest in city infrastructure

£1m funding secured to increase electric vehicle charging in the city

Biggest builder of affordable housing in the city

£2.2 million invested in the voluntary sector per year through the Third Sector Commission, supporting 35,959 people in its first year and levering in £6.27 million

Invested **£23 million** across our 11,500 council homes in 2018/19 - we've had 100% decent homes standard since 2012

Delivered **197** new council homes since 2015 with over 500 in the pipeline

Managing: **45** playgrounds **74** outdoor spaces **55** cemeteries & churches **452** benches

All of Brighton & Hove's adult learning disability residential homes have been rated as 'good' by the CQC

Where does the council's money come from and how is it spent?

The council's money is your money and we take spending and using it really seriously.

We work hard to make sure that we have enough money to pay for things that legally we have to provide such as schools, public health and housing with enough left over to pay for the other services that you tell us are wanted and needed in the city.

It currently costs just over £2 million every day to run your council services meaning in 2019/20 we are spending £757.4 million in total on services across the city.

Our daily spend



£520,000
Schools & education



£20,000
Leisure, parks & open spaces



£160,000
Housing



£120,000
Capital investment



£350,000
Housing benefit



£30,000
Planning & economic development



£160,000
Children's social care



£60,000
Libraries, museums & tourism



£20,000
Public safety



£70,000
Frontline support services



£340,000
Adult social care



£100,000
Highways and traffic management



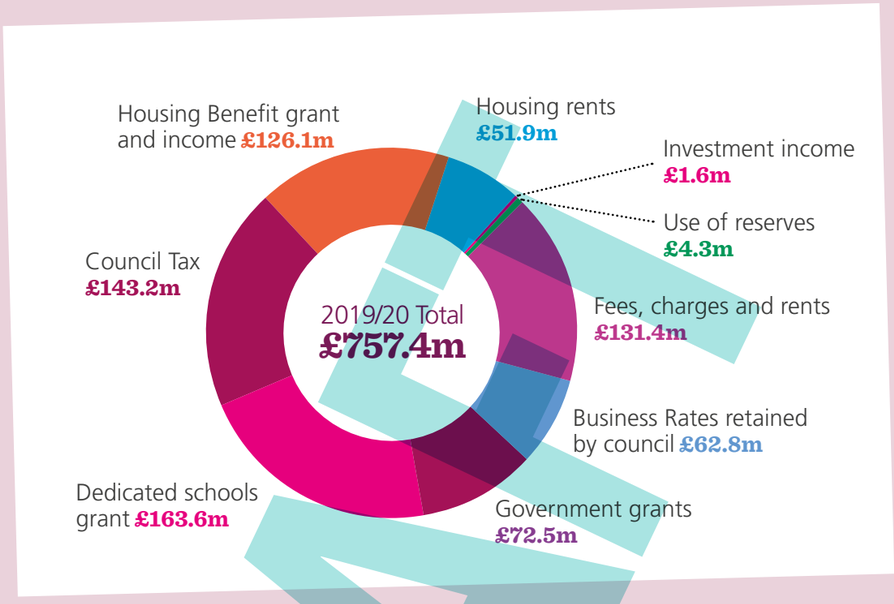
£60,000
Public Health



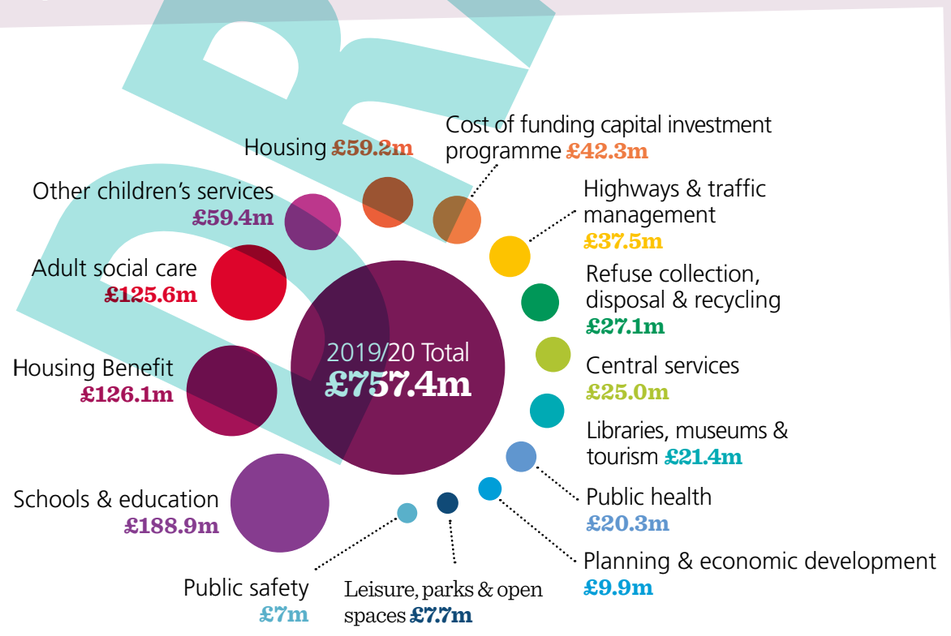
£70,000
Refuse collection disposal & recycling

Learn more about our budget at
www.brighton-hove.gov.uk/bhbudget

Where the money comes from



Services provided



A fairer city a sustainable future

What does a fairer city with a sustainable future really mean?

We have identified six outcomes that we want to achieve for the city. Under each outcome there are five key areas of action and more detail about what we will do. You'll be able to see that we're doing what we said we'd do.

In Brighton & Hove, a fairer city with a sustainable future is

A city to call home

More people than ever are at risk of homelessness. We know that some people who are raised in the city have to leave because they can't afford to live here. Rents and prices are high. Land and properties sit unused and unoccupied. Standards in many private rented homes are unacceptably low.

One of our main priorities is to improve access to good quality housing and reduce homelessness and rough sleeping.

A city working for all

We celebrate the uniqueness of Brighton & Hove and its economy. We need to protect and support the many small businesses that ensure the strength of our city during times of economic uncertainty. We want to develop high quality jobs for local people and to become a global centre for innovation. To achieve this we will work with partners across the Greater Brighton city region and the Coast to Capital Local Enterprise Partnership.

One of our main priorities is to build community wealth, so that local people and organisations benefit from prosperity in the city.

A stronger city

We want the city to be a fair and inclusive place for everyone. We will listen to and work with all our communities to make the city a great place for them to live and thrive. We will ensure that the city continues to be a place where people feel safe, supported and valued. We recognise that some communities are under represented in civic life, in particular, Black and Minority Ethnic (BME) communities and disabled people. We will work to ensure that participation and engagement is fair and representative of the whole city.

A growing and learning city

We are proud of our schools and services for children, young people and families and of the progress they have made. We want them to be among the best in the country. Listening to children and families is at the heart of everything we do. We will focus on inclusion and improving outcomes for the most disadvantaged. We provide services with valued partners so that children and families live happy, safe, healthy and positive lives. We undertake preventative work to support safe and stable families.

A sustainable city

We declared a climate emergency in December 2018. We have to address the climate crisis urgently and make radical changes. The city's transport network is crucial to carbon neutral status and keeping the city moving.

One of our main priorities is to take all action required to make our city carbon neutral by 2030.

A healthy and caring city

We will ensure that the most vulnerable residents in the city are prioritised. We will strive for the very best quality in our services by introducing a new model of delivery which takes into account people's and communities' strengths and assets as well as their needs. We will ensure that people have a strong say in how their local health and wellbeing services develop.

A city to call home

We will



93

Reduce homelessness and rough sleeping

We will work towards eliminating the need for rough sleeping. We will develop homeless guardianship schemes and strengthen partnership working with community and faith projects. We will involve homeless people in a review of the support offered to them and adopt a Bill of Rights for homeless people.

We will provide a **365** day a year night shelter.

We will replace privately run temporary and emergency accommodation with council owned properties. We will negotiate a new agreement with the local charity Seaside Homes to develop better ways of supporting homeless people.

We will treble Housing First provision for accommodating rough sleepers and single homeless people.

To support homeless people we will encourage voluntary contributions from the local tourist industry. We will explore using the Community Infrastructure Levy to provide support. We will also support voluntary organisations and businesses to set up enterprises involving homeless people.

We will identify ways we can increase support for those struggling to afford the cost of housing. This will include making full use of discretionary payments. We will protect anyone at risk of eviction because of arrears resulting from bedroom tax or universal credit shortfalls. We will protect tenants from service charge arrears evictions by introducing and enforcing new licences.

Provide genuinely affordable homes

We have developed an emergency plan to expand housing supply: buying back homes lost through the right to buy or replacing lost council properties with alternatives at affordable rents. We will also increase social housing stock by buying off plan from developers at a discount.

We will consider options for quick build homes to alleviate housing shortages. Over time we aim to reduce costs by directly employing staff and building stable teams to work on council projects. We will look at creating an ethical loan scheme where the council matches community investors. We will also consider the council becoming a developer.

We will buy and build homes to meet a range of housing needs including providing a minimum of **800** additional council homes.

We will ensure there are more council homes at living and social rents. To do this we will fund more truly affordable living and social rents through commercial income.

We will develop **700** other new homes that are as affordable as possible.

We will use public land for community-led housing at a price to maximise social value, identifying ten sites and working with the community to develop them.

A city to call home

We will borrow in order to buy land for affordable housing. We will support innovative developments including small site and hidden homes and mixed property size developments. We will apply a Community Infrastructure Levy to new developments that fully reflects the city's infrastructure needs.

We will increase earlier involvement with leaseholders before undertaking major works to council owned properties. We will ensure that leaseholders' voices are heard and financial support is offered where necessary. We will reduce the interest rates charged when providing a loan for residential leaseholders. We will also expand self-build opportunities.

We will provide **500** shared ownership homes through joint venture and other developments.

Improve private rented housing

We will introduce selective licensing to drive up quality in more of the city's private rented homes. This includes fire safety improvements in private sector properties across the city. We will tackle hazardous housing conditions by increasing capacity for hazard inspection and identifying properties for inspection. To do this we will create a private rented sector team to enforce housing and energy efficiency standards.

We will set up a council run, not for profit, lettings agency. We will support the expansion of good landlord schemes, encouraging landlords to offer homes at lower rents to those on benefits and low incomes. We want to stop landlords refusing to let to people on benefits and will provide advice and support for private renters including support for groups impacted by welfare changes including disabled people and those at risk of eviction. We will protect tenants from service charge arrears evictions. We will set up a tenants' forum for private renters.





Improve council housing

We will introduce a decent environment standard for council estates to go with the decent home standard. We will take forward fire safety improvements in council owned properties across the city and involve residents in improving fire safety. We will work to prevent illegal subletting and fraudulent right to buy applications.

We will work to increase community involvement in housing and meet the Tennant Involvement and Empowerment Standard, for example by using participatory budgeting to decide improvements on estates.

Make better use of existing housing capacity

We will target unoccupied and underused properties including using Compulsory Purchase Orders to bring them back into use. We will provide grants for households relinquishing council tenancies.

We will develop and promote the Rent a Room Scheme to maximise use of spare rooms in under occupied properties. We will explore how to restrict conversion of properties into short term holiday let homes or Airbnb property development.

We will bring at least **650** empty housing properties back into use.







DRAFT

A city working for all

We will



Build community wealth

We aim to become the lead UK city for community wealth building and ethical employment practices. To do this we will use the city's spending power to procure local services for the benefit of our communities. We will bring together the purchasing power of the council and other major institutions such as universities, schools and hospitals to keep money circulating in our local economy. Where possible, we will buy goods and services locally to build the wealth of our communities. We will change the way we outsource services to help small local suppliers win council contracts. We will bring services in house if it will increase social value and improve the development and retention of a highly skilled council workforce.

We will ensure that local home building provides opportunities for young people to develop skills, for example through apprenticeships. We will use regeneration schemes to provide social and sustainability benefits.

We will build Brighton & Hove's reputation as a giving city. We will promote the Brighton & Hove Living Wage, and encourage sign up to a social responsibility and social value charter to provide opportunities to citizens in our most deprived neighbourhoods.

Transition to a sustainable economy

We will promote a sustainable economy by supporting low carbon growth and encouraging businesses to reduce waste and pollution.

> We will establish a circular economy framework focusing initially upon the built environment and visitor economy.

We will work with businesses, universities, regional development organisations and others to become a global centre for innovation and creative, digital and immersive technologies.

We will encourage sustainable development in the city through our planning policies including the City Plan.

> We will support the move to a resilient, zero carbon and smart energy system through the delivery of the Greater Brighton energy plan and facilitate change to a resilient, integrated water environment through the Greater Brighton water plan.

We will work with partners to attract investment in ultrafast broadband infrastructure across the city region.

Support local businesses and charities

We will support local businesses, especially small and medium sized ones, with a focus on cooperatives, community businesses and social enterprises. We will work in partnership with the Greater Brighton Economic Board and Coast to Capital Local Enterprise Partnership to secure investment in the city's infrastructure to support our economy.

Enhance skills and provide housing for the city's workers

We will collaborate with education institutions and businesses to plan for future skills needs and increase the take up of apprenticeships. In particular, we will support women, disabled people and BME groups to achieve their full potential. We will work with our two universities to identify opportunities to transform their innovation and research into new products and services that generate value for the economy. We will build more affordable and key worker housing to help retention and recruitment of staff in public services.

Develop our visitor economy

We will protect the uniqueness of Brighton & Hove with our independent shops, cafés, bars, and our distinctive arts and cultural offer. We will work with local businesses to deliver our visitor economy strategy and destination experience plan.

> We will seek investment to improve the accessibility of our seafront and beaches and invest in seafront infrastructure.

We will continue to work to raise money to restore our heritage including the Madeira Terraces. We will also consider a voluntary tourist tax, a coastal business improvement district, and a combined discount card for tourist attractions, local businesses and public transport.

A stronger city

We will

Tackle crime and antisocial behaviour

Increase participation in civic and community life

Address the causes of poverty and its impact on our communities

Improve access for disabled people

Remain a proud City of Sanctuary

Tackle crime and antisocial behaviour

We will deliver a new three year community safety strategy which will address crime and disorder in the city, including tackling antisocial behaviour, violence against women and girls, hate crime and preventing exploitation, extremism and terrorism.

We will establish a fund to enhance neighbourhood services and community policing to tackle crime and antisocial behaviour.

We will protect spending on independent, LGBTQ inclusive, services for survivors of sexual or domestic violence. We will recommission these services in consultation with victims and other stakeholders. We will support the campaign to have misogyny recognised as a hate crime.

We will identify and tackle the causes of hate crime and antisocial behaviour. We will support activities that bring people and communities together to promote mutual understanding, including awareness raising in schools.

We will invest in an independent support service for people who have experienced racial and religiously motivated hate crime.

We will campaign to ensure that people who attack rough sleepers are prosecuted.

Increase participation in civic and community life

We will work alongside communities on what matters to them. We want to increase participation by using neighbourhood action plans and ward budgets as building blocks for engagement. We will preserve and develop the civic spaces that are vital to communities to ensure that people have a space to meet in and where they can get online, preventing digital exclusion.

We recognise that some communities are under represented in civic life and we will support projects such as Operation Black Vote to ensure that participation is fair and representative of the whole city. We will also invest in a civic leadership programme for under represented groups.

We will continue to invest in a strong and independent voluntary and community sector.

We will promote a city equalities standard together with our partners to promote fair employment practice to tackle the under representation of people from BME communities and disabled people.

We will support community activities and festivals focused on sports, arts and science, bringing people together for the benefit of their neighbourhood and the city.

Address the causes of poverty and its impact on our communities

We will examine the impacts of poverty on individuals and communities and deliver an action plan to make life fairer for those affected by poverty and the consequences of living in poverty.

Improve access for disabled people

We will improve access to all parts of our city and our services for people with physical, sensory and learning disabilities.

We will support disabled people into work, tackle discrimination and disability hate crime, and improve access to learning and leisure activities.

Remain a proud City of Sanctuary

We will continue to play our part in the international refugee crisis and promote our status as a proud City of Sanctuary.

A growing and learning city

We will

Support high quality early years provision

Ensure that schools continue to improve and all children do well

Ensure that no child or family is left behind

Deliver high quality youth services

Promote lifelong learning and transition into adulthood

Support high quality early years provision

We will support our children's centres and local authority nursery schools to provide high quality early years services.

Ensure that schools continue to improve and all children do well

To drive improvement we will establish a Local Education Board to coordinate and improve provision in our schools building on our Family of Schools model.

We will introduce a programme to end the attainment gap for disadvantaged children.

We will support continued improvement in the city's schools and maintain strong Ofsted ratings.

We will extend the successful Every Child a Reader programme and introduce the Every Child Counts programme. We will also develop the role of arts, music and cultural learning including encouraging schools to use the Artsmark programme.

We will introduce a workload agreement to give teachers and professionals more time to teach.

We will reintroduce a local authority supply teacher service to save schools money and ensure high quality teaching.

We will apply the highest standards of safety management in schools and lobby central government to provide funding for the safe removal of asbestos.

We will support early intervention programmes in schools to address sex discrimination and sexual harassment.

We will work with schools to encourage access to sports facilities and kitchens during school holidays. We will promote outdoor education and programmes to increase children's exposure to nature, theatre, music and physical activity.

Ensure that no child or family is left behind

We will ensure that our services promote outcomes in the Every Child Matters standards, assessed by our regulators such as Ofsted. We will protect and improve special educational needs services and other centrally delivered support for schools including mental health. We will maintain services, including out of school services, for children with additional support needs or from disadvantaged groups including children with learning disabilities, and physical disabilities.

We will continue our extensive services for children in care and work to attract, support and retain foster carers. We will lobby central government to properly fund the Staying Put programme for 18 year olds leaving care.

We will open two autism spectrum condition centres.

Deliver high quality youth services

We will identify council owned premises suitable for partners to offer youth services. We will maintain services for refugees and LGBTQ young people and ensure that sexual health services and mental health support are delivered at youth centres across the city.

We will protect funding and review youth services across the city to improve coordination, establish a central youth hub and deliver services directly where possible.

We will give young people a stronger voice in future services.

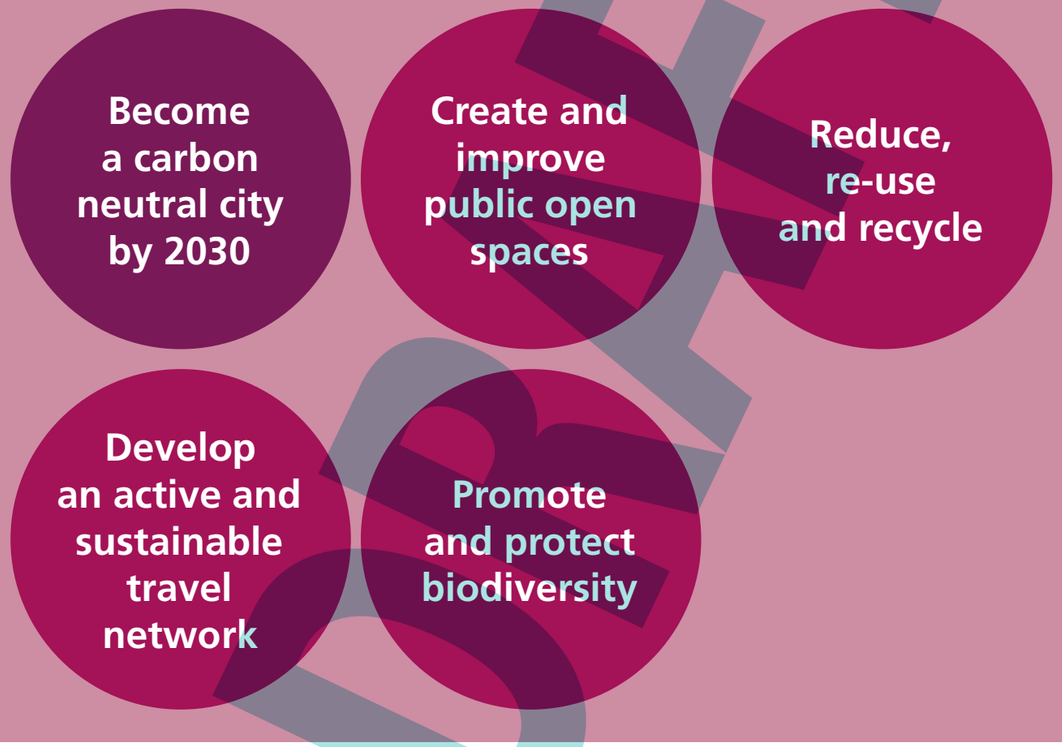
Promote lifelong learning and transition into adulthood

We will promote the benefits of being a university city and strengthen the links between students and residents.

We will ensure that transition services are in place to support young people moving into adult services and that they are integrated.

A sustainable city

We will



Become a carbon neutral city by 2030

We will deliver an ambitious ten year programme to become a carbon neutral city by 2030.

We will set up a climate assembly to develop a programme of action on the climate crisis.

We want to involve young people so we meet the expectations of the next generation. We will work with visionary small businesses to identify ways of making the city carbon neutral.

We will build sustainable council housing to make a significant contribution to our goal. Where possible we will recycle building materials. We will treble spending on solar panels and fuel efficiency measures for council homes.

We will support the development of low carbon housing and sustainable energy. This includes buying energy saving resources in bulk and supplying them at low cost to residents and others. We will support district heat networks and community energy projects.

We will reduce CO_2 emissions from council owned properties and vehicles, with an energy efficiency audit of all council buildings. We will deploy energy efficient technology on council assets. We will increase delivery of self financing energy efficiency and renewables projects.

We will set ambitious fuel poverty reduction targets.

Create and improve public open spaces

We will increase accessible open space for the benefit of residents and visitors.

We will invest in the biodiversity of our parks and in providing children's playground facilities.

We will continue to restore the city's seafront. We will oppose fracking on council land. We will protect properties from surface water flooding by installing sustainable urban drainage schemes. We will tackle graffiti and tagging.

Reduce, re-use and recycle

We will encourage people to reduce the amount of refuse they generate, promote re-use and increase recycling. We will collect a wider range of plastics for reprocessing when market conditions improve.

We will introduce a food waste collection and composting service.

We will install drinking water fountains and promote Refill Brighton & Hove.

Develop an active and sustainable travel network

We will deliver a transport system which provides sustainable travel with investment in walking, cycling and smart traffic signalling. We will encourage mixed mode travel with good transport interchanges and better integration of travel information and ticket purchasing. We will protect vital bus services, especially in outlying areas. We will increase bus use by supporting multi-operator fare payment technology. We will improve air quality through clean, efficient buses and seek further investment in zero emission buses.

We will invest in the maintenance of the city's road and pavement network.

We will install hundreds of on street electric vehicle charging points and rapid charging hubs for taxis.

Promote and protect biodiversity

We will develop a new city downland estate plan with the aim of promoting biodiversity, mitigating climate change and delivering health and social benefits for communities.

We will work towards ending the use of pesticides such as glyphosate across the council and the city.

We will encourage tree planting and green corridors to support biodiversity. We will maintain the quality of our beaches and work with partners on marine conservation. We will refresh the UNESCO biosphere management plan.

We will support the bid for Brighton & Hove to become a Gold Sustainable Food City.

DRAFT

A healthy and caring city

We will



Increase healthy life expectancy and reduce health inequalities

We will focus on preventative services in delivering the high level goals of our health and wellbeing strategy: starting, living, ageing and dying well. This includes promoting healthy eating, physical activity, sexual health, reducing smoking and substance misuse and reducing social isolation. We will ensure that people know where to turn for help and advice to manage their physical health, mental health and social care needs.

We will develop social prescribing, helping people to improve their wellbeing by referral to community led services. We will address the broader determinants of health by improving housing conditions, supporting people into work, improving air quality and encouraging active and sustainable travel.

Support people to live independently

We will ensure that every resident who is eligible receives social care support at a level that enables them to live as independently as possible. We will work to increase understanding and reduce prejudice and discrimination relating to disability and mental health problems. We will work to prevent mental health problems and to identify and treat them as early as possible. We will ensure that all people are respected and supported to participate in decisions about their lives.

Support people in ageing well

We will support older people to stay in their own homes longer.

We will work with voluntary and community sector partners to deliver an Ageing Well service.

We will implement our commitments to become a Dementia Friendly City.

Support carers

We will review and recommission homecare services to ensure that people and their carers have the support they need.

We will support informal carers with a Carers Passport for workplaces.

As one of the largest employers in the city, we will make the council an exemplar in supporting staff who are carers.

Ensure that health and care services meet the needs of all

We will work with our partners to create a joined up health and social care system which provides high quality, seamless care. We will work with BME groups, disabled people and others to audit social care services to ensure that they are accessible and meet the needs of all. We will encourage care homes to pay their staff in line with the Ethical Care Charter principles.

We will extend the council's My Shop card offering discounts in local shops, cafés and leisure venues and subsidised transport to care workers across the city.

We will review the city's Health & Wellbeing Board to ensure that the voices of all are represented and heard.

DRAFT

How will the plan be delivered?

This plan provides the opportunity for us all to come together and play our part delivering a fairer city with a more sustainable future. Over the next three years, we'll make it easy for you to know what we're doing and what we can all do to help make the city fairer for everyone who lives in, works in or visits our city.

Measuring our progress

We will be accountable and open in our actions. Our business plans will set out in detail how we will deliver the six city outcomes. Key performance indicators for each outcome will be monitored quarterly by council committees to make sure we are on track.

A well run council

Council services are under huge pressure as the local population grows, demand increases and our funding reduces. Tough choices will have to be made, through each coming budget round, about what the council is able to deliver and we need to be able to respond to the developing opportunities and challenges for our city, and national regulatory and legislative change.

We will involve people in decision making and service design, and create opportunities for people to help each other. We want to improve the experience of people who use council services and review the different ways people contact us. We plan to move as many services as possible online, whilst ensuring we maintain personalised support for those who need it.

A fair and inclusive council

Brighton & Hove is a vibrant city that is culturally, economically and socially diverse. We take seriously our equality, diversity and inclusion responsibilities under the Public Sector Equality Duty and will challenge inequality in the city and within the council.

We will assess the actions in this plan to identify how they will impact on people from all communities.

We are working towards employing a workforce that reflects and understands the diverse city we serve and want all our staff to experience fairness, dignity and respect in the workplace. We will take a leading role in increasing equality and inclusion in the council and across the city.

A modernising council

We will seek the most effective and efficient way of delivering our services and be well placed to take advantage of social, cultural, environmental and technological change.

We will streamline the way we work, reducing demand on high cost services by preventing problems from arising or dealing with them early on. We will provide the best value for money and an excellent customer experience.

DRAFT

Our customer promise

Our vision of getting things right first time, every time, drives our promise to residents, visitors, people who work or study in the city, local businesses and organisations. We will make it clear how you can contact or access our services. We will be clear and treat you with respect. We will try to understand what you need and get things done.

Our workforce

Our staff are our greatest asset. We can only deliver this plan by recruiting and retaining the right people, making best use of each employee's skills, talents, abilities and experience.

We will be clear to our present and future staff what our employer offer is and how they will be supported to do their jobs well. Our People Promise is a series of five commitments from the council to our workforce.

We promise

- to support staff wellbeing in the workplace
- to be a fair and inclusive employer that values diversity and individuality
- to provide opportunities for staff to do their best through training and developing skills
- to recognise and reward great work
- and to be a good place to work so we can do our best for the city

Working in partnership

We believe that collaborating with other organisations is the key to better outcomes for the city. Brighton & Hove Connected is the main city wide partnership and provides a single vision and direction for the city. It brings together the different parts of the public sector, as well as business, community and voluntary sectors.

The City Management Board is made up of decision makers from each of the major public services, the council, police, NHS, fire service, probation service, and the two universities.

The Health and Wellbeing Board works to improve the health and wellbeing of the population of Brighton & Hove through improved and combined health and social care services.

We also work with other councils and regional bodies to promote economic, environmental and social wellbeing for the city. These include the Greater Brighton Economic Board and the Coast to Capital Local Enterprise Partnership which aim to increase investment in the Greater Brighton city region.

For information about the city's partnerships visit
www.bhconnected.org.uk

DRAFT

6799 Brighton & Hove City Council Communications Team

Council	Agenda Item 58
19 December 2019	Brighton & Hove City Council

Subject:		**Review of the Constitution – December 2019** – Extract from the proceedings of the Policy & Resources Committee meeting held on the 5 December 2019
Date of Meeting:		**19 December 2019**
Report of:		**Executive Director Finance & Resources**
Contact Officer:	Name:	**Lisa Johnson** **Tel: 01273 291228**
	E-mail:	lisa.johnson@brighton-hove.gov.uk
Wards Affected:	All	

FOR GENERAL RELEASE

Action Required of the Council:

To receive the item referred from the Policy & Resources Committee for approval:

Recommendation:

(1) That the proposed changes to delegations in respect of Planning Committee and to relevant Protocols be agreed as indicated in paras 4.1 to 4.3 and Appendices 2-4;

(2) That the proposal at para 4.12 to amend the Council Procedure Rules in respect of the arrangements of the council's Urgency Sub Committees be agreed;

(3) That the proposal at para 4.15 for a gender-neutral Constitution and the proposal for a BME invitee to attend Policy & Resources Committee meetings as referred to in paragraph 4.9 be agreed;

(4) That the Chief Executive and Monitoring Officer be authorised to take all steps necessary or incidental to the implementation of the changes agreed by the Policy & Resources Committee and by Full Council, and that the Monitoring Officer be authorised to amend and re-publish the Council's constitutional documents to incorporate the changes; and

(5) That the proposed changes come into force immediately following their approval by Policy & Resources Committee or adoption by Full Council, as appropriate.

BRIGHTON & HOVE CITY COUNCIL

POLICY & RESOURCES COMMITTEE

4.00pm 5 DECEMBER 2019

BRIGHTON TOWN HALL - COUNCIL CHAMBER

MINUTES

Present: Councillors: Platts (Chair), Yates (Deputy Chair), Mac Cafferty (Opposition Spokesperson), Mears (Group Spokesperson), Allcock, Clare, Gibson, Moonan, Shanks and Simson

MINUTE EXTRACT

PART ONE

92 REVIEW OF THE CONSTITUTION – DECEMBER 2019

92.1 The Committee considered the report of the Executive Lead Strategy Governance & Law which set out the proposed changes to the Council's Constitution. The proposals set out in the report had been considered by the cross-party Constitutional Working Group.

92.2 Councillor Mears referred to Recommendation 2.3, asked for confirmation that a BAME individual would only attend a meeting whilst it was considering Part One items and not Part Two items. The Executive Lead Strategy Governance & Law said that a BAME representative would attend a meeting as an 'invitee', and under the Local Government Act 1972 it was not possible to co-opt a non-councillor to be a full member of a committee and as they would not be a full member they could not take part in any Part Two item.

92.3 Councillor Moonan said that under the previous administration a policy had been introduced to buy back homes. This was a quick way to get homeless people housed, and she was pleased that the policy was being extended. As many family homes the Council wanted to purchase were above the current limit, the Delegated Authority was being increased. The Constitution Working Group wanted the more marginalised groups in the city to have a voice in the decision making process of the Council, and whilst that was a detailed piece of work and would take some time, they wanted to do something straight away and having a BAME representative at P&R Committee meetings would signal the Council's commitment.

92.4 **RESOLVED:**

(1) That the proposal to make changes to the Scheme of Delegations to Officers in Part 6 of the Council's Constitution relating to the Council's planning functions as indicated in Paragraphs 4.1-4.3 and Appendix 1 be agreed;

(2) That the proposal to change Part 6 of the Council's Constitution to increase the financial threshold in relation to officer delegations governing the acquisition of residential property in para 4.5 be agreed;

(3) That the proposal in para 4.9 to invite a BAME individual to attend Policy & Resources Committee early in 2020 be approved as a first step to increase participation and input by protected characteristic groups;

(4) That the proposal in paragraphs 4.11 which relates to the arrangements for the Council's Member Working Groups be agreed;

(5) That the draft protocol regarding the use of urgency powers attached at Appendix 6 and referred to at paragraphs 4.13-4.14 be agreed; and

(6) That Full Council be recommended to approve the changes recommended to it in paras 2.7 to 2.9 below.

RESOLVED TO RECOMMEND:

(7) That the proposed changes to delegations in respect of Planning Committee and to relevant Protocols be agreed as indicated in paras 4.1 to 4.3 and Appendices 2-4;

(8) That the proposal at para 4.12 to amend the Council Procedure Rules in respect of the arrangements of the council's Urgency Sub Committees be agreed;

(9) That the proposal at para 4.15 for a gender-neutral Constitution and the proposal for a BME invitee to attend Policy & Resources Committee meetings as referred to in paragraph 4.9 be agreed;

(10) That the Chief Executive and Monitoring Officer be authorised to take all steps necessary or incidental to the implementation of the changes agreed by the Policy & Resources Committee and by Full Council, and that the Monitoring Officer be authorised to amend and re-publish the Council's constitutional documents to incorporate the changes; and

(11) That the proposed changes come into force immediately following their approval by Policy & Resources Committee or adoption by Full Council, as appropriate.

Council	Agenda Item 58
19 December 2019	Brighton & Hove City Council

Subject:		**Review of the Constitution**
Date of Meeting:		**19 December 2019** 5 December 2019 – Policy & Resources
Report of:		**Executive Lead Officer for Strategy, Governance & Law (Monitoring Officer)**
Contact Officer:	**Name:**	**Abraham Ghebre-Ghiorghis** **Tel: 01273 291500**
	Email:	**abraham.ghrebre-ghiorghis@brighton-hove.gov.uk**
Ward(s) affected:		**(All Wards);**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report proposes changes to the Council's Constitution for approval by Policy & Resources Committee and (where relevant) Council. The proposals set out in the report have been considered by the cross-party Constitutional Working Group (CWG).

2. RECOMMENDATIONS:

Policy and Resources Committee:

2.1 That the proposal to make changes to the Scheme of Delegations to Officers in Part 6 of the Council's Constitution relating to the Council's planning functions as indicated in Paragraphs 4.1-4.3 and Appendix 1 be agreed.

2.2 That the proposal to change Part 6 of the Council's Constitution to increase the financial threshold in relation to officer delegations governing the acquisition of residential property in para 4.5 be agreed.

2.3 That the proposal in para 4.9 to invite a BAME individual to attend Policy & Resources Committee early in 2020 be approved as a first step to increase participation and input by protected characteristic groups.

2.4 That the proposal in paragraphs 4.11 which relates to the arrangements for the council's Member Working Groups be agreed.

2.5 That the draft protocol regarding the use of urgency powers attached at Appendix 6 and referred to at paragraphs 4.13-4.14 be agreed.

2.6 That Full Council be recommended to approve the changes recommended to it in paras 2.7 to 2.9 below.

Full Council:

2.7 That the proposed changes to delegations in respect of Planning Committee and to relevant Protocols be agreed as indicated in paras 4.1 to 4.3 and Appendices 2-4.

2.8 That the proposal at para 4.12 to amend the Council Procedure Rules in respect of the arrangements of the council's Urgency Sub Committees be agreed.

2.9 That the proposal at para 4.15 for a gender-neutral Constitution and the proposal for a BME invitee to attend Policy & Resources Committee meetings as referred to in paragraph 4.9 be agreed.

Policy & Resources Committee and Full Council:

2.10 That the Chief Executive and Monitoring Officer be authorised to take all steps necessary or incidental to the implementation of the changes agreed by the Policy & Resources Committee and by Full Council, and that the Monitoring Officer be authorised to amend and re-publish the Council's constitutional documents to incorporate the changes.

2.11 That the proposed changes come into force immediately following their approval by Policy & Resources Committee or adoption by Full Council, as appropriate.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Council is required to keep its Constitution under review with a view to achieving efficiency, economy and effectiveness. The cross-party Constitutional Working Group (CWG) was set up to assist with this by considering proposals and advising the Council on proposed changes to the constitution. The current members of the CWG are Councillors Moonan (Chair), Littman and Wares . The proposals set out in the report were discussed and agreed by the CWG on 12th September 2019 and on 4th November 2019.

4. PROPOSALS

Planning delegations

4.1 This proposal seeks to make provision for a process whereby Permission in Principle and Technical Details Consent may be decided by Planning Committee or by Officers. This is required in order to bring the Constitution into line with current legislation.

4.2 The Town and Country Planning (Permission in Principle) Order 2017 (as amended) introduced the ability to apply for Permission in Principle for residential development and for the subsequent Technical Details Consent. Permission in Principle can be granted in relation to location, land use and amount of development. The following development proposals are excluded from the ability to apply for Permission in Principle: major development; EIA development; householder development and development likely to have a significant effect on sites within the Habitats Regulations.

4.3 The changes to the Constitution which are proposed are attached as Appendices 1 to 4 inclusive. The proposals have been approved in principle by Planning Working Group members in addition to the Constitution Review Group. The proposals allow officers to determine applications for Permission in Principle unless the existing call-in triggers apply, in which case the application would be determined by Planning Committee.

Proposal to change officer delegations in relation to the acquisition of residential property

4.4 On 18/9/2019 the Housing and New Homes Committee received a report with a recommendation that the financial limits applied to the officer delegations in relation to land acquisition be reviewed. That Report is attached as Appendix 5.

4.5 The current officer delegations enable the acquisition of land, after consultation with the Chair of P&R, up to a value of £250,000. As indicated in the report to Housing and New Homes Committee, it was proposed that the officer delegation limit be increased to £500k for the purpose of the acquisition of residential land only. This increase was suggested as a means of assisting the Council in meeting its priorities for homes and emergency accommodation. The increases in delegation will enabling the Council to act quickly to secure successful purchases. It is proposed to do an annual report to Policy & Resources Committee on acquisitions so that Members have the opportunity to consider how the arrangements work in practice and review them if necessary.

4.6 In addition to the Housing and New Homes Committee, the proposal has been reviewed by the Constitution Review Group, which approved the principle of increasing the threshold.

Proposals to encourage and develop Black, Asian and Minority Ethnic ('BAME') engagement and participation in Council decision-making

4.7 The Constitution Review Working Group considered the findings of the Operation Black Vote Audit which was published earlier this year. That audit placed this Council at the very bottom of a league table nationally insofar as BAME representation in the Council's elected members was concerned. While that audit was carried out prior to the May 2019 local elections, the Constitution Review Group also noted the findings of the Global HPO report which was brought to the Policy and Resources Committee in October 2019 and which considered race equality within the council's workforce.

4.8 The CWG considered the actions that might lawfully be taken as a proportionate means of tackling the issues which had been identified. CWG also noted the work done by other councils to develop civic leadership programmes with under-represented groups with the aim of encouraging the engagement of persons with one or more protected characteristics.

4.9 The Working Group seeks this Committee's approval to agree to the attendance of a BAME individual to provide a 'lived experience' perspective at a meeting of Policy & Resources Committee in early 2020 as a first step. It is proposed that the choice of nominees be led by relevant community groups and that the

nominee be invited to attend this Committee rather than being co-opted onto it due to the legal prohibition which prevents co-optees to committees which regulate or control the council's finances (S102 Local Government Act 1972).

4.10 It is further proposed to explore options for a broader programme to offer civic engagement opportunities, including to other protected characteristic groups. This will be the subject of a further report to this Committee in due course.

Arrangements for proceedings of the Council's Member Working Groups

4.11 In July 2019 this Committee approved terms of reference which had been prepared for each of the Council's existing permanent member working groups ('MWGs'). In order to ensure that those groups function in a way which is consistent, it is proposed that the following general expectations be embedded in Part 4 of the Constitution:-

- That the Chair of each MWG shall normally be appointed from the council's largest political group unless Policy & Resources Committee has made other express provision;
- That while MWGs will be expected to achieve consensus where possible, the Chair shall have the right to exercise a casting vote;
- That the political groups may change any of its nominees or provide substitutes for any of its nominees to any MWGs.

Arrangements for proceedings of Urgency Sub Committees

4.12 There is currently an express requirement that an Urgency Sub Committee *'shall consist of the Chair of the Committee and two other Members nominated by the Group Leader or Leaders as appropriate to meet the requirements for the allocation of seats between political groups'*. It is proposed to amend Council Procedure Rule 22.1 to allow for flexibility for the political group from which the Chair comes to choose their nominee rather than require the Chair to be a member of the Urgency Sub Committee. The amendment will state that the Chair of the Committee should '*normally'* be the Chair of the parent Committee. This is considered to create an expectation without imposing an express requirement.

Arrangements for use of urgency powers

4.13 The CWG considered a draft protocol on the use of urgency powers which is intended to clarify the arrangements for the use of Special Committee meetings, urgency Sub-Committees and Officer urgency powers. The draft protocol is attached at Appendix 6. The protocol includes two flow charts illustrating:-

(1) the hierarchy of decision making, meaning that officer urgency powers are only used when it is not reasonably practicable to convene a member decision making body; and

(2) the specific steps that need to be taken when officer urgency powers are used.

4.14 The protocol requires an annual report on the use of officer urgency powers to be reported in May to P&R. Further it requires each exercise of officer urgency

powers to be recorded on an Officer Decision Record which will include the details of the consultation undertaken with the Chair/Deputy Chair of the relevant Committee before taking a decision.

Incorporating gender-neutral language in the Council's Constitution

4.15 The Council's Constitution is a living document which evolves over time to reflect the Council's arrangements for exercising the powers vested in it. It has been noted that the Constitution does not currently use gender neutral language, but instead deploys gendered pronouns which rely on binary oppositions ('he' and 'she').

4.16 It is proposed that the Constitution be amended throughout so as to consistently incorporate language which is fully gender-neutral. Making these changes to this key council text would reinforce the Council's commitment to describing and categorising people in ways that are inclusive and supportive. The proposal would be achieved by using 'they' to replace 'he' or 'she' as a singular pronoun in appropriate situations, while making any small adaptations considered necessary in order to ensure that there is no detrimental impact on clarity of meaning.

4.17 This Committee is asked to recommend that full Council formally approve the above proposal.

5. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

5.1 The Committee or Council could decide not to implement the changes set out in the report.

6. COMMUNITY ENGAGEMENT & CONSULTATION

6.1 The cross-party Constitutional Working Group has considered the proposals and has made the recommendations in this report.

7. CONCLUSION

7.1 The proposals reflect the Council's ongoing efforts to review its Constitution to ensure that it is reflective of current practice and priorities and to achieve clarity and increased efficiency. It is therefore recommended that they are pursued.

8. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications

8.1 There are not expected to be any significant financial implications arising from this report.

Finance Officer Consulted: James Hengeveld Date: 7.11.19

Legal Implications:

8.2 Policy & Resources Committee and, where specified in this report, full Council have the authority to make the changes to the Council's Constitution which are set out in the report. The intention is for the proposals to be implemented with immediate effect.

Lawyer Consulted: Victoria Simpson Date: 5.11.19

Equalities Implications:

8.3 The proposals in this report have been reviewed for adverse equalities implications. As indicated in the body of this report, the proposals at paras 4.7 and 4.15 are made with the aim of discharging the council's equalities duties. Both of these separate initiatives take as their primary focus the imperative of ensuring greater inclusivity in terms of the council's approach, and the need to ensure that the council takes a proportionate approach to seeking actively to ensure participation and engagement insofar as it is able to do so.

Sustainability Implications:

8.4 None

Any Other Significant Implications:

8.5 None identified

SUPPORTING DOCUMENTATION

Appendices:

1. Part 4 - the Scheme of Delegations to Committees - (tracked changes) (extracts)

2. Part 6 - the Scheme of Delegations to Officers (tracked changes) (extracts)

3. Part 8.5 – the Protocol for Members regarding Planning Applications (tracked changes) (extracts)

4. Part 8.6 – the Protocol for Representations at Planning Committee (tracked changes) (extracts)

5. Report to Housing and New Homes Committee of 18th September 2019

6. Draft Protocol on the use of Urgency Powers.

Extract from Part 4 - Scheme Of Delegation to Committees and Sub Committees

PLANNING COMMITTEE

Explanatory Note

This Committee exercises the Council's functions in relation to development control matters.

Delegated functions

1. To consider and determine applications submitted under the Planning Acts for planning permission, permission in principle, technical details consent, listed building consent, and reserved matters pursuant to major planning applications.

2. To consider and determine applications for the display of advertisements submitted under the Town and Country Planning (Control of Advertisements) (England) Regulations.

3. To determine whether prior approval applications for the construction, installation, alteration or replacement of telecommunications masts submitted under Part 24 Schedule 2 of the Town and Country Planning (General Permitted Development) Order 1995 should be granted or refused.

4. To exercise any other function of the Council under the Planning Acts whether as a local planning authority or otherwise which may be referred to it by the Executive Director Economy, Environment and Culture or other officer authorised by him/her.

[**NOTE**: The Council may approve a restricted pool of Members to serve as members or substitute members of the Committee, all of whom have undergone basic training and continue to undergo the mandatory training for such Members. The mandatory training will take place at least twice a year. Where such a pool has been approved, any meeting of the Committee must comprise only Members from the pool; no substitution by non-pool Members will be allowed.]

Extract from Part 6 - Scheme of Delegation to Officers

SCHEDULE 4

Functions delegated to the Executive Director Economy, Environment and Culture in relation to Planning:

Part I

(1) To determine planning applications (including identifying the need for and the settling of terms of Planning Obligations under S106 of the Town and Country Planning Act 1990, the imposition of conditions where consent is granted and the renewal of existing permissions) where the applications relate to the following categories of development:-

(i) alterations/extensions to single dwellinghouses and buildings containing residential flats;
(ii) works within the curtilage of buildings which are incidental to their lawful use;
(iii) changes of use;
(iv) applications submitted pursuant to Article 4 Directions;
(v) alterations to or installation of shop fronts;
(vi) the provision of no more than 9 new dwelling units (net increase), either by he construction of new buildings or by conversion of existing buildings;
(vii) extensions and alterations to non-residential buildings;
(viii) applications relating to the formation of accesses, fire escapes, replacement windows, flag poles, the erection of and alterations to walls, fences or other means of enclosure, floodlights, radio and TV masts, telecommunications apparatus, material changes to the external appearance of buildings, including extensions;
(ix) renewals of temporary permissions;
(x) applications to vary or delete conditions attached to planning permissions;
(xi) all other minor planning applications not referred to above.

(2) Applications for permission in principle.

(3) Applications for technical details consent (including identifying the need for and the settling of terms of Planning Obligations under S106 of the Town and Country Planning Act 1990 and the imposition of conditions where consent is granted).

~~(2)~~ (4) Applications for consent under the Advertisements Regulations.

~~(3)~~ (5) Applications for Listed Building Consent.

~~(4)~~ (6) To undertake all consultations, notifications and publication of advertisements on behalf of the Council in relation to any of the matters listed above.

Extract from Part 8 - Codes and Protocols

PART 8.5 PROTOCOL FOR MEMBERS REGARDING PLANNING APPLICATIONS

Note: for the purposes of this Protocol reference to "planning applications" shall include reference to applications for permission in principle and technical details consent.

1. Lobbying and neutrality

(a) Members of the Planning Committee should not organise the support of, or opposition to, planning applications.

(b) No Member should lobby Members of the Planning Committee outside the formal procedures for objecting to or making representations on planning matters, as set out in this Protocol and the Protocol for Public Representations at Planning Committee.

(c) Planning Committee Members should retain a neutral position on planning applications prior to determination at the Committee and, in order to retain the impression of being free from bias, should avoid making public statements as to their support of, or opposition to, any application.

(d) Planning Committee Members should use a standard paragraph in letters to lobbyists etc explaining they will retain a neutral position on planning matters and applications until such time as the application is put to the Committee for determination. However, before doing so Members may wish to take advice from officers as to whether the application will be determined by the Committee or under delegated authority.

A suggested standard paragraph is as follows:

"As a Member of the Planning Committee I am unable to comment on planning application reference…….until such time as the application comes before the Committee for determination"

(e) Ward Members not sitting on the Committee should be informed of applications in their ward.

(f) Members not sitting on the Planning Committee may make public their personal view on any development issue and may take advice from the Executive Lead for Strategy, Governance & Law before commenting on any particular planning application. Where views are expressed it should be made clear that the merits of the application will be dealt with by the Committee at the determination stage in accordance with statutory criteria.

(g) No Member should appear to be delivering planning outcomes to lobbyists, agents, third parties, objectors, etc. prior to a planning application being determined.

(h) Members who have been lobbied or taken part in any discussions on an application, and then substituted onto the Committee, should declare this at the Committee. Members who have expressed a strong view on a particular application should seek advice from the Executive Lead for Strategy, Governance & Law prior to being substituted. 12/05/2016

Note
Planning Committee Members have to retain a "neutral" position on any application for the very fact that they are part of the decision making process and cannot be seen to side with either the applicant or objectors prior to the date of determination of the application when all relevant facts are known. As decision makers, they should not be seen to be prejudging the application, nor to be influenced by those with whom they have a special relationship as fellow Members, at any stage prior to determination. This would not therefore debar a local Member from speaking on an application at the determination stage but would prevent a Member from lobbying Members at any time leading up to determination.

The Planning Committee is constrained to take into account only relevant planning considerations, against the background of the Development Plan and other material planning considerations. Planning decisions should not be unduly influenced by party politics, or individual Members. Should Members be allowed to become involved in applications to the extent of organising support/objection the Council's credibility in the decision making process could be compromised.

For example, therefore, Members should not distribute or organise the distribution of leaflets urging the public to support or oppose particular planning applications. However, Members could set up meetings to gain the public's views on particular applications, but in so doing regard must be had to codes (c) and (f) above.

For further advice regard should be had to the Local Government Association's publication: "*Probity in Planning*" which contains detailed guidance on good planning practice for Councillors and officers dealing with planning matters.

2. Declaration of Members' Interests

(a) All Members should be conversant with the Code of Conduct for Members.

(b) Non-voting Planning Committee Members should leave the committee room during consideration of any application in which they have an interest which would amount to a disclosable pecuniary interest had they been voting Members of the Committee.

[Note: Members should be aware that officers are bound by the Code of Conduct for Employees and should declare financial and non – financial interests.] 12/05/2016

3. Procedures and Conduct of Meetings
(a) Chair's Briefings

(i) Chair's briefings should be held after the draft agenda has been set and officers' recommendations made.
(ii) The prime purposes of Chair's briefings should be:-
 to discuss the issues with the Chair, Deputy Chair and Opposition Spokesperson;
 to ensure that the rationale for officers' recommendations is fully explained;
 for the Chair to highlight possible problem items and potentially controversial applications;
 to consider arrangements for site visits;

(b) Officer - Member Briefings

(i) Member briefings should be held after the draft agenda has been set and officers' recommendations made.
(ii) The purpose of Member Briefings is to ensure that the rationale for officers' recommendations is fully explained.
(iii) Officer-Member briefings are to be fact finding exercises only.

(c) Committee Meetings

(i) An opportunity will be given for members of the public to address the Committee. Those wishing to make representations must follow the Protocol for Public Representations at the Planning Committee.
(ii) A representative of the Executive Lead for Strategy, Governance & Law should be present at all Committee meetings.
(iii) Ward Members not sitting on the Committee, any ward Member of an adjoining ward or other ward which will be affected by the application, representatives of Rottingdean Parish Council (in relation to applications which affect the area of the Parish Council) and representatives of a neighbourhood forum designated under the provisions of the Localism Act 2011 (in relation to applications which affect the area of the neighbourhood forum) have the right to attend the Planning Committee and speak for a maximum of 3 minutes to any application within/affecting their ward or area.

Note
This includes the right of ward Members to speak on an application where they are Members of the Applicant Committee (see also note to Code 6(a)). 12/05/2016

4. Site Visits

(a) Site visits should follow established criteria. A copy of the criteria is attached as Appendix 1.
(b) A Code of Conduct for site visits should be followed. A copy of the Code is attached as Appendix 2.
(c) It is recommended that all Planning Committee Members should attend site visits.
(d) Planning Committee Members with an interest in an application should not attend the site visit for that application.

5. Decisions Contrary to Officer Recommendation

(a) Members must give tenable and substantiated reasons when refusing and approving planning applications.
(b) Reasons for rejection and approval should be fully minuted.
(c) A recorded and named vote should be taken where applications are rejected or approved against officer recommendations.
(d) Officers must ensure that Members are fully aware of the reasons for their recommendation and the implications for the Committee of a decision against the recommendation – this would include the cost implications of any appeal.
(e) Officers will ensure that any decision (including a decision that is contrary to officer recommendation) is appropriately supported.

6. Planning Applications made by the Council

(a) There is no automatic prohibition on Members of the Planning Committee speaking and voting on planning applications made by Committees or Sub-Committees of which they are also Members. However, Members need to be mindful of the following:

- there may be a potential public perception that, by being part of the application and determination process, Members may not retain a neutral and objective position;
- Members must confine themselves to determining planning applications on the basis of material planning considerations only and not take into account non-planning considerations;
- Members should not take part in the planning decision if their Membership of the Applicant Committee or Sub-Committee, or other circumstances, would lead to a charge of bias or predetermination.;
- Members should consider each situation on its own merits and, if the position is unclear, err on the side of caution and not take part in the determination of the application;
- If Members are unclear or need advice, they should consult the Executive Lead for Strategy, Governance & Law or the Planning Lawyer.

12/05/2016

7. Relationship between Members and Planning Officers

(a) Planning officers who work closely with Members must ensure that their professional judgment is not compromised by the nature of their professional relationship with Members.
(b) Members should recognise that Chartered Planners are governed by their code of professional conduct obliging RTPI members to make professional and independent recommendations.

(c) Informal relationships between officers and Members should be avoided as this may create difficulties for chartered planners where there are genuine differences of approach to a planning matter.

Note
Members need also to be familiar with the Code of Conduct for Member/Officer Relations found elsewhere in this part of the Constitution.

12/05/2016

APPENDIX 1
Criteria for Planning Committee Site Visits

1 The Purpose of Site Visits

1.1 The purpose of a Site Visit is:-
 to enable Members of the Committee to obtain a fuller appreciation of the likely impact of proposed development, which may not be apparent from the officers' report and presentation or form a public vantage point outside the site, so as to inform better decision making in respect of that application;
 to enable Members of the Committee to assess the impact of schemes that they have previously approved so as to inform decision making in the future (site visits to implemented schemes).

1.2 The purpose of a Site Visit is not:-
 to allow ward Councillors, applicants, objectors or other members of the public to lobby Members of the Committee, nor
 to duplicate or check up on the site assessment made by the planning case officer.

2. Protocol for calling for Site Visits

2.1 Any Member of the Committee or Councillor is entitled to make a request for a site visit explaining how they consider their request meets the criteria set out above. It will be entirely at the discretion of the Committee to decide whether it wishes to carry out a site visit in that particular instance.

2.2 A request for a site visit may be made by a Member either at Planning Committee or at an Officer-Member Briefing. Officers may suggest or formally recommend that a site visit be made. A site visit will be held unless the majority of Members, present at the time when the request is considered, disagree. Should a site visit be agreed the ~~planning~~ application will be heard at, or deferred until, the next Planning Committee following the site visit.

2.3 Members will be encouraged to identify potential cases for Committee site visits at the earliest possible occasion so as to avoid unnecessary deferments. 12/05/2016

APPENDIX 2

Site Visits by Planning Committee

Code of Conduct

1. Authorised attendance at a site visit shall be limited to elected and co-opted Members of the Planning Committee, a representative of the Executive Director Economy, Environment and Culture and the applicant or his or her representative. Councillors representing the ward in which the application is submitted or adjacent wards affected by the application will also be invited to attend.

2. There shall be no discussion of the merits of any application during the site visit. Such discussions will only take place at a meeting of the Committee.

3. During the site visit Members should endeavour to remain in a group and must not enter into individual discussions with the applicant, the applicant's agent or any objector, supporter or ward Councillor.

4. The applicant, objectors, supporters and ward Councillors shall be treated equally during the site visit,

5. Neither the applicant, nor their representative nor any objector, supporter or ward Councillor shall be permitted to make representations to Members of the Committee during a site visit but they may, however, give any purely factual information which is required by Members and which cannot be ascertained by viewing alone.

6.. Site visits are normally arranged for the afternoon of the day immediately prior to the following Planning Committee. It is the responsibility of the case officer to:

(a) Notify the applicant/owner of the site that a visit is to take place and explain the procedure;
(b) Liaise with the Clerk to the Committee regarding the time and place of the visit so that a letter can be sent with the next agenda notifying Members of the visit.
(c) Ensure that the report is included on the next agenda.

Extract from Part 8 - Codes and Protocols

PART 8.6 PROTOCOL FOR PUBLIC REPRESENTATIONS AT PLANNING COMMITTEE

The following procedure shall be followed at the Planning Committee meetings for the purpose of enabling members of the public to make representations. This protocol supplements the Council Procedure Rules and the two should be read together.

1. A planning officer will introduce the ~~planning~~ application and display any plans as well as bringing to Members' attention any new matters that have arisen since the agenda was prepared. Members may ask questions of the planning officer.

2. Objectors (or their representative) have an opportunity to address Members. Where there is more than one objector, the clerk to the Committee will require the objectors to nominate a spokesperson. Exceptionally, and at the Chair's discretion, more than one objector may be allowed to speak, but only where new material issues are to be raised. Members may ask questions of the objectors only for the purpose of clarifying matters of fact already raised during the objector's presentation.

3. Ward Members, a representative of Rottingdean Parish Council and a representative of a neighbourhood forum may address the meeting in relation to any ~~planning~~ application before the Planning Committee that falls within or affects their ward/area.

4. The applicant (or their representative) has an opportunity to make representations in support of the application, but only if the recommendation is to refuse or there are ward Members, a representative of Rottingdean Parish Council, a representative of a neighbourhood forum or objectors speaking against the application. Applicants will make their representations after all other speakers have spoken. Applicants will be notified of any notice of intention to speak. Members may ask questions of the applicant only for the purpose of clarifying matters of fact already raised during the applicant's presentation.

5. Members may receive legal and other professional advice as necessary during the proceedings.

6. In the interests of efficient despatch of business, the following rules regarding speaking time per application will apply:

 A total time of 3 minutes shall be allowed for all objectors. Where the Chair permits more than one objector to speak, the time will be divided equally among the objectors (unless they come to some other arrangement between themselves.)

05.12.2018

 A total time of 3 minutes shall be allowed for Ward Members. Where more than one Ward Member wishes to speak, the time will be divided equally among the Ward Members (unless they come to some other arrangement between themselves)

 A total time of 3 minutes shall be allowed for Rottingdean Parish Council

 A total time of 3 minutes shall be allowed for a neighbourhood forum

 A total time of 3 minutes shall be allowed for the applicant.

 In exceptional cases, these timings may be extended at the Chair's discretion. An exception may involve an abnormal weight of objections or support or where the application is particularly complex.

7. A person wishing to speak at a meeting of the Committee shall give written notice of his/her intention to do so to Democratic Service 4 clear days before the meeting (Normally, the Committee meets on Wednesdays which means the notice has to be received by the preceding Friday). The applicant and other persons wanting to make representations will be notified of the arrangements for public speaking by being sent a copy of this protocol together with contact details. Applicants may be given the right to speak notwithstanding that they have failed to give the required notice.

8. For the purposes of this protocol:-

 the term "objector" shall mean a person who lives in the immediate vicinity of the application site or who otherwise may reasonably be considered to be potentially directly affected by the proposed development

 the term "neighbourhood forum" means a neighbourhood forum designated as such in accordance with the Localism Act 2011

Requests or applications for the discharge or variation of completed s106 planning obligations

9. In those cases where the request or application is to be determined by the Committee, developers or their agents requesting or applying for the variation or discharge of completed s106 planning obligations have the opportunity to address the Committee for a total of 3 minutes in support of their request/ application. The opportunity arises whether the officer recommendation is to agree or to refuse the request/application. Four clear days' notice of the intention to address the Committee shall be given to Democratic Services. Members may ask questions of the developer /agent only for the purpose of clarifying matters of fact already raised during the developer's/agent's address.

..... 05.12.2018

10. The Committee or the Chair may waive any of the requirements of this protocol if satisfied on legal and professional advice, and only in **exceptional** circumstances, that it is appropriate to do so in the circumstances.

HOUSING COMMITTEE	Agenda Item 9 Brighton & Hove City Council

Subject:		**Home Purchase Policy update**	
Date of Meeting:		**Housing Committee 18 September 2019 Policy and Resources Committee 10 October 2019**	
Report of:		**Executive Director – Neighbourhoods, Communities & Housing**	
Contact Officer:	**Name:**	**Diane Hughes**	**Tel: 01273 293159**
	Email:	**Diane.hughes@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Housing & New Homes Committee agreed a Home Purchase Policy in September 2017 to enable the purchase of homes funded by the Housing Revenue Account (HRA). This supported the council to:

- Maximise the supply of affordable homes in the city as outlined in the Housing Strategy
- Meet housing need through the housing register
- Utilise retained Right to Buy receipts thereby avoiding the need to return capital funds to the government, and reducing the impact on the HRA's borrowing headroom.

1.2 A 12 month pilot took place from November 2017 which focused on the council buying back former council homes where the council had the right of first refusal. In September 2018 Housing & New Homes Committee was presented with feedback on the pilot and agreed revisions to this policy. These revisions included the council also being able to consider other acquisitions opportunities such as affordable housing gained through planning (S106 sites).

1.3 This report provides an update on the operation of the policy.

2. RECOMMENDATIONS:

That the Housing Committee:

2.1 Notes the outcomes of the Home Purchase Policy to date.

2.2 Recommends that Policy and Resources Committee agree an additional HRA capital budget of £3.000m for the scheme for 2019/20.

2.3 Recommends to the Constitutional Working Group a review of the financial limits applied to officer scheme of delegations.

2.4 Recommends use of the rent support reserve held within the HRA reserves to enable consideration of reduction of rents under the Home Purchase Policy to achieve social rents or 27.5% living wage rents.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The citywide Housing Strategy adopted by council in March 2015 has as priority one *Improving Housing Supply* with a commitment to prioritise affordable housing provision in the city. The city has an Affordable Housing Brief based on evidenced local housing needs which reflects the very pressing need for affordable homes in the city.

3.2 A Home Purchase Policy which enables the purchase of properties for which there is demand, at the right price, supports the priority to increase affordable homes in the city. The policy outlined a number of ways that the purchase of homes can take place. The 'buy back' scheme has allowed the council to buy back former council homes where the council has the right of first refusal. This has been extended into a wider offer to other leaseholders/freeholders of former council owned homes who may wish to sell their properties back to the council.

3.3 **Buy back scheme for former council owned homes (right of first refusal and open market sales)**

Since the scheme began the council has received 83 offer notices[1]. Of these:

- 23 properties have been purchased to be let as either general needs or temporary accommodation properties
- 23 properties have offers agreed and sales are proceeding with the council's legal services
- 7 properties are currently under consideration
- 30 properties are not proceeding.

3.4 A breakdown of the properties that the council has purchased or are purchasing is as follows:

Size	**Number**
Studio	2
1 bedroom	13
2 bedroom	24
3 bedroom	7

Property use	**Number**
General needs	26
Temporary accommodation	20

[1] As at 31 July 2019

The reasons for properties not proceeding are:

Reason	Number
Property over £250,000 threshold	13
Property did not offer the council value for money	7
Owner did not accept the offer	4
Owner withdrew property from sale	6

3.5 Full details of the offers are included in Appendix 1. The scheme has demonstrated that there are a good number of opportunities coming through and the wider offer to extend the scheme has proved popular with leaseholders and freeholders. The primary assessment tool for deciding whether a property should be used as general needs or temporary accommodation is based on the financial viability of the purchase. Secondary considerations are the proportion of properties used general needs and council owned temporary accommodation to create a balance in the programme, and opportunities to achieve rents at 27.5% living wage (to date four general needs properties have achieved 27.5% Living Wage rent). At present the scheme is operating on approximately 60% general needs and 40% temporary accommodation basis with this proportion able to be adjusted at any time (subject to financial viability of the purchases).

3.6 The budget for the scheme for 2019/20 is £7.000m. The council has spent £1.863m with a further £5.598m forecast to be spent committed bringing the total spend to £7.461m as at July 2019. To allow the scheme to continue for the remainder of 2019/20 a further budget of £3.000m is being requested as detailed in paragraph 4.1.

Delegated authority limits

3.7 Whilst the threshold of £250,000 has not proved to be a barrier to this policy, it has resulted in the purchase of smaller properties (typically 1 and 2 bedroom homes). An analysis of Land Registry sales of three and four bedroom properties in the past two years in council housing localities show that sales of 118 three bedroom homes fell into the following price bands:

Price band	Number of homes
£200 - 249,000	10
£250 - 299,000	31
£300 - 349,000	47
£350 - 399,000	21
£400,000 plus	9

Findings from the sales of 20 four bedroom homes were:

Price band	Number of homes
£280 - 299,000	2
£300 - 349,000	6
£350 - 399,000	8
£400,000 plus	4

3.8 The Executive Director of Neighbourhoods, Communities & Housing's current financial limit under officers' delegated power is £0.250m as outlined in the Scheme of Delegations. The Land Registry analysis shows that an increase in the Scheme of Delegations limit to £0.500m would enable a considerable increase in the scope of the scheme. Any amendment to the officer scheme of delegations would need approval from Policy & Resources Committee and is a matter for the cross party Constitutional Working Group to consider.

Other opportunities

3.9 Alongside the purchase of former council homes, other opportunities may become available to purchase other properties or land for housing. Affordable housing is required to be provided on site at all new housing developments providing more than 15 units (City Plan Policy CP20). These developer contributions providing affordable housing are typically known as S106 sites. The council is now actively considering these sites, and also looking at a range of acquisition opportunities to provide new homes.

3.10 Where time permits a business case will be developed for each potential purchase to be considered at the cross party Housing Supply Member Board and Housing Committee for approval.

3.11 In some exceptional cases, there may be a benefit in considering the need for the use of an Urgency Sub Committee to be able to respond to opportunities arising in the market. This would ensure transparency in decision making. In addition Urgency Powers are also available if, due to urgent timing, committee approval could not be sought in advance. The Executive Director Neighbourhoods, Communities & Housing in consultation with Executive Director for Finance & Resources, may use their Chief Officer Urgency Powers in order to meet a deadline. Consultation must take place with the Chairs of Housing Committee (HC) and Policy & Resources Committee (PR). Any decisions taken under Urgency Powers are reported to Housing Committee and Policy & Resources Committee in accordance with the procedure outlined in the Scheme of Delegations.

4. Budget and resources

4.1 With the budget of £7.000m for 2019/20 now fully committed, a further capital budget allocation is required to allow the scheme to continue operating at its current level during this financial year. A further £3.000m will allow the purchase of approximately 12 further properties, bringing the total number acquired under the Home Purchase Policy's 'Buy Back' scheme in 2019/20 to an estimated 42.

4.2 The scheme is currently managed, through the equivalent of one full time post supporting the operation of the scheme.

5. ANALYSIS & CONSIDERATION OF OPTIONS

5.1 The Home Purchase Policy offers the opportunity to maximise council owned homes. Reports presented at Housing & New Homes Committee in September 2017 and 2018 provided a range of options, with the preferred one being to have in place a policy which allows both the buy-back of former council homes and other acquisitions.

6 COMMUNITY ENGAGEMENT & CONSULTATION

6.1 Tenants and leaseholders were consulted on the development of the Home Purchase Policy through the Area Panels in Summer 2017 and on the subsequent changes to the policy in 2018.

7. CONCLUSION

7.1 The purchase by the council of additional affordable homes will help meet the council's strategic objectives to increase housing supply as set out in the council's Housing Strategy.

7.2 The Home Purchase Policy will continue to be kept under review to determine the success of the scheme and to inform future budget decisions.

8. FINANCIAL & OTHER IMPLICATIONS:

Financial implications

8.1 The forecast expenditure for 2019/20 is £7.461m; this already exceeds the approved budget of £7.000m for the financial year. Without committing further budget to the scheme it will result in having to pause the purchase of two or three homes as there will be insufficient budget to fund the purchases.

8.2 If approved, the additional £3.000m budget would form part of the 2019/20 HRA capital programme and would be funded by up to 30% Right to Buy Receipts, with the remaining assumed from HRA borrowing. However, the actual funding of the budget will be considered in line with the whole of the HRA capital programme at the end of the financial year. As stated in the body of the report, the additional budget would support a further 12 homes to be purchased.

8.3 Each property purchased through this policy is subject to a viability test. This test is designed to ensure that purchases are providing value for money for the council. The results of the tests are indicative only and used as a decision making tool for officers to consider, alongside other factors when deciding to proceed with the purchase or not. The results can be seen in appendix 1 to this report. To date seven properties have been rejected on a value for money basis, due to the valuation being high for for the properties and the rental income not supporting the purchase.

8.4 The viability test will continue to be applied to any new properties coming forward and will be used to provide assurance that if the delegated authority is raised, properties will only be purchased if they provide good value for money as well as matching the type of property required by the council.

Finance Officer Consulted: Monica Brooks *Date: 12/8/19*

Legal Implications:

8.5 Section 17 of the Housing Act 1985 confers a power on local housing authorities to acquire houses. The continued acquisition of property for use as residential accommodation is clearly within the council's powers.

8.6 The Council's Scheme of Delegations to Officers sets a limit of £250,000 on officers' powers for the disposal and acquisition of land. The Council is required to keep its constitution under review with a view to achieving efficiency, economy and effectiveness. The Cross-Party Constitutional Working Group (CWG) was set up to assist with this by considering proposals and advising the Council on proposed changes to the constitution. It is therefore appropriate for any proposals to amend the constitution to be directed initially to the Constitution Working Group, rather than Policy & Resources Committee which is the body with the power to approve changes to the Scheme of Delegations to Officers.

Lawyer consulted: Liz Woodley *Date: 07.08.19*

8.7 Equalities Implications:

The Home Purchase Policy supports the delivery of the city's Housing Strategy and an increase in housing supply will extend opportunities to accommodate households on the Housing Register who are on housing need.

8.8 Sustainability Implications:

Purchased properties are required to meet the Brighton & Hove Standard and seek to be energy efficient, minimise carbon emissions and reduce water usage.

SUPPORTING DOCUMENTATION

Appendices:

Appendix 1: Home Purchase Policy outcomes

Documents in Members' Rooms **None**

Background Documents Home Purchase Policy

DRAFT PROTOCOL ON THE USE OF URGENCY POWERS BY OFFICERS

This Protocol clarifies expectations on the use of urgency powers by officers of the council and is to be read with reference to **the Officer Flowchart** and **the Officer Checklist** provided below.

When may officer urgency powers be used?

General delegations in Part 6 of the Scheme of Delegations provide Chief Officers with urgency powers in two contexts:

1) where an emergency has been declared or where an officer acting as gold command considers it necessary to take appropriate steps under the Council's emergency planning, resilience or business continuity procedures; and
2) in any situation where it is not reasonably practicable to obtain prior approval of a Committee or Sub-Committee.

The use of urgency powers in accordance with 1) is not dealt with in this Protocol, which governs the use of urgency powers in scenario 2) only.

A: Officer Flowchart: is it possible to obtain the prior approval of a Committee or Sub Committee as a first resort?

Officers are required to follow the Flowchart below. This summary is to be read alongside it.

When a decision needs to be made urgently, officers are expected to ask themselves the following questions in sequence, having regard to the Council Procedure Rules:

1. Can the matter be put to an ordinary Committee meeting? The dates for the council's committees are scheduled considerably in advance.

2. If a meeting of the Committee is either not scheduled within relevant deadlines or is happening too soon for members to have opportunity to scrutinise the proposals, then officers should ask: is it practicable to convene a special meeting (CPR rule 19)? These may be called by the Chair or Deputy Chair or by one quarter of the voting members to the Committee by requisition. The process involves scheduling an additional meeting of the entire Committee to consider one or more agenda items.

3. If it is not practicable to convene a special meeting, whether for timetabling, room availability or other reasons, then officers should ask: is it practicable to convene an Urgency Sub Committee of the Committee (rule 22)? This involves convening a dedicated meeting of three members of the Committee on a cross party basis. The fact that it may be called at short notice mitigates against optimum scrutiny as any decision is made by a smaller pool of members (albeit on a cross party basis).

If 1, 2 and 3 have been considered but are not possible, then officers may consider exercising delegated urgency powers. The expectation is that all relevant decisions will be referred to a member body unless it is not reasonably practicable to convene one of 1-3 ab ove.

B: Officer Checklist: Exercising Urgency Powers

The Officer Checklist below is to be used only where it is not considered reasonably practicable (having reviewed the Flowchart) to obtain Committee or Sub Committee approval

Where the flowchart indicates that it is not reasonably practicable to obtain Committee approval, then urgency powers may be available as long as the following safeguards are met:

- The Officers must firstly consult the Chair of the Committee or Sub Committee before taking any decision;

- The Officer must complete an Officer Decision Record using the template (see annex at the end] and including a record of the consultation undertaken;

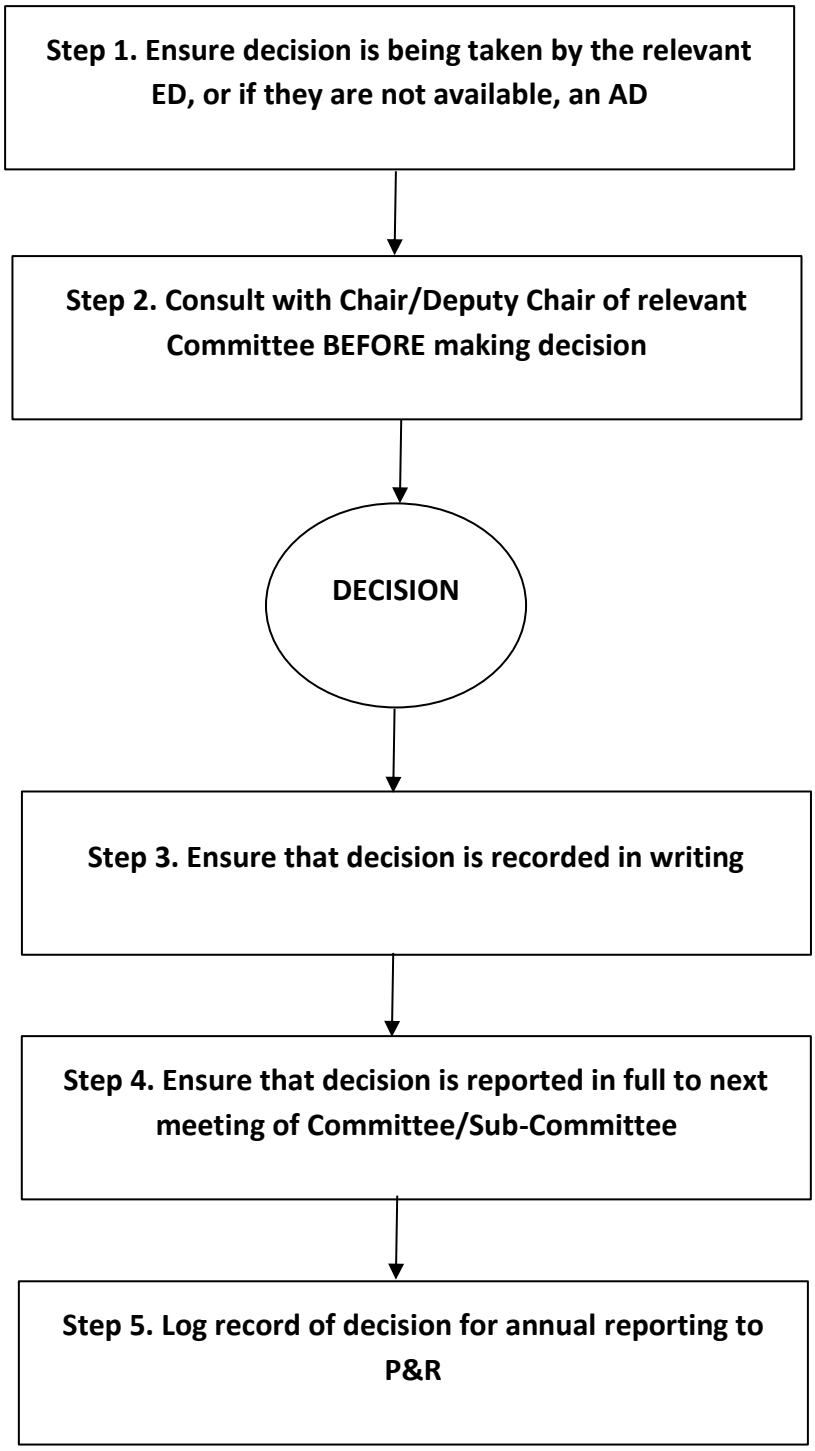
- The officer decision must be taken at Chief Officer level or in their absence at Assistant Director level;

- After the decision has been taken, it must be reported to the next scheduled Sub Committee or Committee for information so as to ensure as much transparency as possible;

- A copy of the Officer Decision Record must be logged with Democratic Services so that it can be included in the annual report to P&R which reports on decisions taken by officers using urgency powers.

B: OFFICER CHECKLIST: EXERCISING URGENCY POWERS

(NB Only applicable where not reasonably practicable to obtain approval from a member body – see flowchart)



Extract from the Scheme of Delegations to Officers – Urgency Powers:

7. Urgency Powers (with relevant provisions are highlighted in grey).
(1) In cases where an emergency has been declared or when an officer acting as gold command considers it necessary to take appropriate steps under the Council's emergency planning, resilience or business continuity procedures:-

(a) After consultation with the Leader of the Council or a Deputy Leader, to exercise any of the functions, whether within the service area of the chief officer or otherwise, in cases of urgency where it is not practicable to obtain prior approval of the relevant Committee or Sub-Committee. See also notes (i) to (iv) below.
(b) To approve expenditure of up to £1,000,000, the action taken to be reported for information to the Leader of the Council and Group Leaders as soon as practicable. See also notes (i) to (iv) below.
NOTES
(i) Contact the Emergency Planning & Resilience Duty Officer on 07540 675 169 in connection with the exercise of the above delegated powers.
(ii) The Leader of the Council or in his / her absence a Deputy Leader shall be informed as soon as is practicable if it appears likely that any such emergency will be declared.
(iii) If it is not possible or practicable for an officer who would normally exercise the above delegated powers to do so, the powers may be exercised by the officer who is designated to be in charge under the Council's emergency planning or business continuity procedures or any officer appointed by him / her to act on his / her behalf.
(iv) If it is not possible or practicable for the officer to consult the Leader or a Deputy Leader before exercising the above delegated powers, the officer may exercise the powers without doing so but shall take such steps as appear appropriate at the time to keep Members informed of the action taken.

(2) In any other cases of urgency:-
(a) After consultation with the Chair (or in his / her absence, a Deputy Chair) of the relevant Committee or Sub-Committee, to exercise any of the functions within the service area of the officer in cases of urgency where it is not reasonably practicable to obtain prior approval of a Committee or Sub-Committee.
(b) The action taken shall be reported, as appropriate, to the Committee or Sub-Committee.

This record relates to urgent decisions taken by Chief Officers under the Scheme of Delegation to Officers Paragraph 7(2).

RECORD OF URGENT DECISION TAKEN BY [insert Job Role]

SUBJECT:

CONTACT OFFICER:

REASONS FOR URGENCY AND WHY NOT PRACTICABLE TO HOLD A SPECIAL MEETING OR URGENCY SUB-COMMITTEE:

DETAILS AND OUTCOME OF CONSULTATION WITH THE CHAIR/DEPUTY CHAIR OF RELEVANT COMMITTEE:

DATE OF CONSULTATION WITH CHAIR/DEPUTY CHAIR:

THE DECISION:

REASONS FOR DECISION:

DETAILS OF ANY ALTERNATIVE OPTIONS CONSIDERED:

LEGAL IMPLICATIONS:

Name ***Date***

FINANCIAL IMPLICATIONS:

Name ***Date***

DATE OF NEXT COMMITTEE MEETING TO WHICH THE DECISION WILL BE REPORTED:

Date:

Signed:

Executive Director

Logged by Democratic Services Officer for Annual Report:

Name: Date:

Council	Agenda Item 59
19 December 2019	Brighton & Hove City Council

Subject:		**Sussex Health and Care Plan -The Local Response to the NHS Long Term Plan Item referred from the Special Health & Wellbeing Board meeting**		
Date of Meeting:		**19 December 2019**		
Report of:		**Executive Lead Officer for Strategy, Governance & Law**		
Contact Officer:	**Name:**	**Penny Jennings**	**Tel:**	**01273 291006**
	E-mail:	penny.jennings@brighton.gov.uk		
Wards Affected:	**All**			

FOR GENERAL RELEASE

Action Required of the Full Council: To receive the item referred from the Health & Wellbeing Board for information:
Recommendation: That the report be noted.

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

9.30am 5 NOVEMBER 2019

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present:

BHCC: Councillor Moonan (Chair); Councillor Shanks (Opposition Spokesperson) and Nield.

Brighton and Hove CC : Andrew Hodson, Chair of CCG, Co -Deputy Chair of the Board**,** Lola Banjoko and Ashley Scarff.

Non-Voting Members present: Rob Persey (Statutory Director Adult Social Care), Nicola Rosenberg (in substitution for the Director of Public Health), David Liley (Brighton and Hove Healthwatch)

PART ONE

27 SUSSEX HEALTH AND CARE PLAN -THE LOCAL RESPONSE TO THE NHS LONG TERM PLAN

27.1 The Board considered the joint report of the Executive Managing Director, Brighton and Hove Clinical Commissioning Group and the Executive Director of Health and Adult Social Care, Brighton & Hove City Council which set out the proposed local response to the NHS Long Term Plan.

27.2 It was noted that the Special Meeting had been called to consider and deal with this matter as a formal response to the Plan was required by 15 November 2019 and this requirement had not been known before the last Health and Wellbeing Board meeting took place in September 2019. The Special meeting had therefore been called and timed in order to allow time for the discussion and comments from the Board to be taken into account.

27.3 It was explained that the NHS Long Term Plan (LTP) had been published. Each area of the NHS was required to produce a response to this plan explaining what they needed to do and what they wished to achieve in response to the needs of their local community whilst also achieving the key objectives as set out in the NHS Long Term Plan. The Sussex Health and Care Partnership which was made up had formed a Partnership of the CCG's and health bodies that covered East and West Sussex and Brighton and Hove, the Sussex Health and Care Partnership (SHCP). The respective local authorities would be collaborating with the Partnership and needed to produce

a five-year strategic plan for NHS England outlining what they wished to achieve. The Full Plan and the three-area placed based plans were set out in Appendix 1 to the report. The plan represented the CCG response to the local health and care needs of the populace and included commitments to change how health and care organisations worked together to transform patient pathways, addressed financial deficit addressed the workforce gap and delivered the significant number of initiatives included in the Long-Term Plan.

27.4 In answer to questions by the Chair, Councillor Moonan, it was explained that work and consultation on the Plan as presented had been on-going since January of this year and had to be agreed by a specified deadline. A response was required, and it had to follow a timetable, it had been prepared as part of the on-going long-term planning process locally, was integral to the allocation of funds in the medium and longer term.

27.5 The Deputy Chief Executive and Chief Operating Officer of the Sussex and East Surrey CCGs, Karen Breen, responded to the concerns raised by the Deputees and others who were present in the Chamber. Ms Breen explained that the CCG were very aware of the concerns which had been voiced locally about the risks to the NHS of privatisation. Nothing set down in the Long-Term Plan suggested that working in this way would increase privatisation in the NHS. What was very clear however from what had been said by the local population as well as nationally was that more needed to be done to increase collaboration across organisations so that care was much more seamless and joined up. Importantly, no new care system was being set up, the integrated care system for Sussex would not be a decision-making body. Decision making would remain with the various CCGs and the NHS trusts serving Brighton and Hove.

27.6 In responding to the questions raised in respect of the consultation process it was explained that discussions had taken place with a number of partner organisations and that more than 4,000 con conversations had taken place with Brighton and Hove residents about the response. The Director of Commissioning and Deputy Chief Officer for the Brighton CCG, Ashley Scarff confirmed that this was the case also that meetings where discussions had taken place had been public meetings. Those elements of the Plan which required approval by the other constituent CCG partners had already taken place and approval been given.

27.7 The Statutory Director for Adult Care, Brighton and Hove City Council, Rob Persey, stated that the Plan as put forward set out the with the aims of partners in order to provide cohesive strategies which were aligned. The Plan would form the basis of continued discussion and he confirmed that those discussions were regular and on-going.

27.8 Lola Banjoko and Ashley Scarff, CCG, stated that the plan represented a continuation of what was already in place and how that would continue to be delivered, it set out the key aims and importantly strategies to address the longer-term health needs of those who had multiple conditions and sought joined up delivery of services. As with all strategic documents, changes were

anticipated. The recent Queen's Speech had highlighted that it was intended that legislation would be introduced to further support the NHS, an Adult Social Care White Paper was also awaited, and these could impact on the Plan and it was very important therefore to have a continuing Plan in place which indicated the direction of travel for services. There was an on-going commitment to engaging with the Board and local residents as/when the Plan needed to be refreshed. Jayne Black, CCG, confirmed that the Plan had been drawn up in consultation with staff and also provided them with a degree of surety going forward.

27.9 The Chief Executive, Brighton and Hove Healthwatch, David Liley, explained that Healthwatch had an on-going monitoring role and in that capacity had regular conversations with the public, the CCG, third sector organisations, patients and the public in relation to service delivery. Healthwatch were of the view that going forward the manner in which consultations could be broadened out could be improved and that that was worthy of discussion. The Plan itself was an important building block and should therefore in his view be noted and supported in general terms.

27.10 The Chair, Councillor Moonan, noted all that had been said and the passions and concerns which had been voiced by those in the public gallery. She understood and shared some of those concerns, which in her view formed part of a wider debate on the future of the NHS. She considered that means by which making consultation processes could be improved or made more inclusive in future should be explored in order to see whether/what practical changes could be made. Noting the Plan was however a necessary process and seeking to delay that process would not in her view be beneficial for anyone. The Board had the power to note the Plan and a further update would be brought forward to the January 2020 meeting. She considered that it could be helpful for this matter to be forwarded to Full Council for information and for elected Councillors if they considered it appropriate to put together a Notice of Motion or to use other mechanisms to broaden the debate in relation to the wider concerns and issues which had been raised.

27.11 Councillors Shanks and Nield stated that they also shared a number of the concerns expressed and considered that it was very important that the Plan had been brought forward for the Board's consideration and that it was important for a wider debate to take place in the correct forum. They considered that the Plan should be noted as per the report recommendations, ideally deferred and should also go forward to Full Council for information.

27.12 In response to issues raised during the course of the discussion, The Head of Legal Services, Elizabeth Culbert, confirmed that it would be appropriate for the report to be forwarded to Full Council for information should the Board wish to do so.

27.13 A vote was then taken. The Chair formally put the proposed amendment that consideration of the report be deferred, which was lost. The Chair then put the recommendations as listed in the report to the vote which was carried.

27.14 **RESOLVED –** That the Board agrees to the following:

(1) To note the further developed SHCP 5-year strategic plan set out at Appendix 1 to the report; and

(2) That a progress update report will be provided to the January Health and Wellbeing Board. This will update the Board on the:

- Submission and outcome;
- Development of the operational delivery plan;
- Financial implications for Sussex and the Brighton and Hove Based Plan;
- Any Targets that have been set and monitoring arrangements.

27A ITEMS REFERRED FOR FULL COUNCIL

27.15 The Chair noted that Councillor Shanks had requested that item 27 be referred to the full council for information and this had been accepted by the Board.

27.16 **RESOLVED:** That Item 27 – "Sussex Health and Care Plan – The Local Response to the NHS Long Term Plan" be referred to the Council for information.

The meeting concluded at 11.15am

Item 27

Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title: Sussex Health & Care Plan – the local response to the NHS Long term Plan

Date of Meeting: 5th November 2019

Report of: Lola Banjoko, Executive Managing Director, Brighton & Hove Clinical Commissioning Group,
Rob Persey, Executive Director of Health & Social Care, Brighton & Hove City Council

Contact: Ashley Scarff, Director of Partnerships and Commissioning Integration, Brighton & Hove Clinical Commissioning Group
Email: ashley.scarff@nhs.net

Wards Affected: ALL

FOR GENERAL RELEASE

By reason of the special circumstances, and in accordance with section 100B(4)(b) of the 1972 Act, the Chair of the meeting has been consulted and is of the opinion that this item should be considered at the meeting as a matter of urgency because of the timescale for submitting the Sussex Health & Care Partnership's response to the NHS Long Term Plan.

Note: The special circumstances for non-compliance with Council Procedure Rule 3, Access to Information Procedure Rule 5 and Section 100B(4) of the Local Government Act 1972 (as amended), (items not considered unless the agenda is open to inspection at least five days in advance of the meeting) were that the NHS Long Term Plan requires a formal response by 15th November 2019 and this requirement was not known before the last Health and Wellbeing Board meeting in September 2019. A Special Meeting has therefore been called and timed in order to have time for the discussion and comments from the Board to be taken into account.

Executive Summary

The NHS Long Term Plan (LTP) has been published. Each area of the NHS has to produce a response to this plan explaining what they need to do and what they wish to achieve in response to the needs of their local community while achieving the key objectives as described in the NHS Long Term Plan.

The Sussex Health & Care Partnership (made up of the CCGs and health bodies that cover East and West Sussex and Brighton & Hove) has formed a Partnership: the Sussex Health & Care Partnership (SHCP). Local Authorities will be collaborating with the Partnership. The SHCP have to produce a 5 year strategic plan for NHS England outlying what they wish to achieve. This report and presentation outline the further developed Plan which will be submitted to NHS England on 15th November. The full Plan and the three area Placed Based Plans can be found in Appendix 1.

The Sussex Health and Care Plan will help to **improve lives, extend lives and save lives.**

The plan represents our response to the **local health and care needs** of our populations and the national ambitions and expectations set out of the **NHS Long Term Plan**.

The Brighton & Hove elements within this **build on existing plans in Brighton & Hove**:

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

The plan includes commitments to change how our health and care organisations work together, transform patient pathways, address our financial deficit, address our workforce gap and deliver the significant number of initiatives included within the Long Term Plan.

The key **ambitions** of the plan are:

- To create a health and care system that better **meets the health and wellbeing needs** of our populations.
- To create new ways of working focusing on **helping people stay healthy** for longer and give them **greater support to manage their own health** when they do become ill.
- To support all aspects of people's lives that contribute to their health and

wellbeing.
- To develop teams from across organisations that work together to give greater joined-up care that is right for the individual.
- To create a system that better involves and supports the 1.6m people who live across Sussex and the 30,000 staff who work within our health and care organisations.

The plan is a **continuation of the work** that has already taken place over the last few years to improve and join-up health and care services. It has been built on the local transformation plans that were already in place and uses the clinical evidence from the Population Health Check developed by local doctors, clinicians and professionals.

The plan represents the collective response across our health and care partners to the **challenges** we all face around the rising demand on services, finances and workforce shortages.

To meet the ambitions of the plan, we **need to strengthen existing relationships** between primary, acute, community and mental health services, and reinforce relationships with Local Authorities, including district and borough councils, and the voluntary and community sector.

The plan has been developed with the involvement and input of partners, clinicians, specialists, health and care professionals, staff, and previous consultation with our public. It is a **collective effort** across our partners and is currently being formally agreed through all statutory organisations, before it is finally submitted on 15 November.

The core purpose of the plan is to bring **real benefits** to the lives of our populations:

- Improved, equitable access to high quality, safe and joined-up care.
- Greater access to health and care professionals with the most appropriate skills for people's specific needs.
- Health and care tailored in a more personalised way at home, or as close to home as possible.
- People will be better supported to improve their own health and wellbeing.
- Better availability of non-clinical solutions that will keep people healthier for longer.
- Easier interactions with health and care services through technology.
- Greater joined-up support for people with multiple health conditions.
- Better support to people in care homes to ensure safe and high quality care.

Glossary of Terms

BAME – Black and Minority Ethnic
BHCC – Brighton & Hove City Council
CCG – Clinical Commissioning Group
NHS – National Health service
NHS E – National Health Service England

NHS I – National Health Service Improvement
NHS LTP – National Health Service Long Term Plan
SHCP = Sussex Health & Care Partnership

1. Decisions, recommendations and any options

1.1 That the Board agrees to the following:-

1.1.1 To note the further developed SHCP 5 year strategic plan as set out at Appendix 1;

1.1.2 That a progress update report will be provided to the January Health & Wellbeing Board. This report will update the Board on the:

- Submission and outcome
- The development of the operational delivery plan
- Financial implications for Sussex and the Brighton & Hove Place Based Plan
- Any targets that have been set and monitoring arrangements.

2. Relevant information

2.1 The NHS Long Term Plan has been published. A copy can be downloaded here https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

2.2 Areas have to submit a local response to the NHS LTP, a strategic plan outlining how they are going to meet the aspiration of the NHS Long Term Plan and to meet the health needs of the population at both a Sussex level as well as a Place / local authority area level.

2.3 The supporting presentation will take the Board through the work achieved to date and outline the process after submission of the Plan on 15th November 2019.

Progress since the draft Plan was presented to the Board September 2019

2.4 Further work has been done to the Plan. There are key features which reflect local areas needs including:

- An overarching introduction of the Sussex wide provision and aspirations
- Local Place Based Plans for each area within Sussex to reflect each areas specific needs.

Place Based Plans are drawn from local engagement and consultation;

2.5 Each of the Place Based Plans underpinning the overarching Sussex wide plan reflect the individual CCGs within their area. The Sussex Health and Care Partnership covers three distinct areas that are each coterminous with

the Local Authority areas concerned. This will make planning joint local support for our populations significantly easier.

2.6 Brighton & Hove city council have been very active in developing the Place based response. The response to the LTP sits alongside our local Joint Health and Wellbeing Strategy, reflecting the prevention agenda necessary to support the health of our population over a life course, and address our local population health and care needs as identified in the Joint Strategic Needs Assessments. Summary assessments of our population and the wider determinants of health for the people of Brighton & Hove that underpin the local plan are set out in section 2 and are drawn directly from the joint Health & Wellbeing Strategy.

2.7 Our Place Based Plan draws on extensive consultation over the last 3 years using the Big Health & Care Conversation as well as utilising other engagement e.g. the development of the Health & Wellbeing Strategy and the refresh of the Transformation Plan for children and young people's mental health.

2.8 Consultation and engagement does not finish now as this is a continuous process. In Brighton & Hove we will continue to build on the public and patient engagement to develop and inform commissioning and delivery of the plan in particular hard to reach groups. The CCG and BHCC have also commissioned 10 Voluntary and Community Sector (VCS) organisations under the Third Sector Investment Programme, to engage with local people in specific groups such as BAME, carers, young men and people with disabilities on health and social care.

2.9 Each of the Place Based Plans has been tailored to meet the needs of the local population. The Brighton & Hove Place Based Plan relates directly to the joint Health & Wellbeing Strategy and for consistency uses the '4 Wells': Starting Well, Living Well, Ageing Well, Dying Well to frame the implementation of the plan. Using the same framework will support the alignment of our local health and wellbeing plans with the local implementation for the NHS Long Term Plan. This alignment will ensure that our planning, implementation and reporting are all more joined up.

Following 15th November submission

2.10 We will be submitting the SHCP LTP response to NHS England to meet the deadline of 15th November 2019. Following submission all plans will be scrutinised by NHSE to ensure they meet local people's needs as well as achieve the key objectives of the NHS Long Term Plan.

2.11 The NHS organisations within the SHCP have had had 3 year funding levels agreed, although this is not the case for local government. Having a Plan will not impact on the overall health finances of the Sussex Health & Care Partnership, an agreed plan will enable and allow the focus of spend to

change as required to best meet local needs e.g. mental health spend in Brighton & Hove.

2.12 We will be open and transparent in how progress is reported on implementing the Brighton & Hove Place Based Plan and the SCHP Plan overall. Working with the 4 Wells framework will make it easier to see how the Plan together with the Health & Wellbeing Strategy of the city are concurrently being achieved. Any annual reporting process will come to this Board given the impact on achieving the city's Health & Wellbeing Strategy.

2.13 Following submission and scrutiny the SHCP could be asked by NHSE to review areas of the Plan if NHSE require further assurance that those areas of the plan will achieve the NHS Long Term Plan objectives and /or our targets. Any such areas identified will be reviewed and addressed locally ahead of a final plan publication on 2nd December. If any amendments have to be made and there is an impact on the Place Based Plan this will be reported to the Board.

Risks and liabilities

2.14 An important aspect of the Sussex wide plan and our approach is demonstrating the validity and value of the 3 identified local Places within Sussex, mapped to the 3 local authority areas. The NHS LTP is modelled with single 'places' for each health and care partnership or ICS, our partnership believes strongly that such a singular approach does not best serve the populations of Sussex.

2.15 We have not asked the Board to fully approve the Plan as we are aware that there is significant content that is health led and Sussex wide. However there are key areas such as the preventative provision and alignment with public health, social prescribing, post hospitalisation care and alignment with social care, and children's services, that without our key Local Authority Partners the Plan cannot deliver to Brighton & Hove residents.

Refreshing the Plan

2.16 Like all strategic documents we are anticipating change. The Queens speech highlighted that there will be legislation introduced to further support the NHS. We are also awaiting the Adult Social Care White Paper. We do not know what the impact on our Plan will be. We are committed to engaging the Board and local residents as and when refreshing the Plan is needed.

3. Important considerations and implications

3.1 Legal:

From the CCG

There is a regulatory requirement set out in the NHS LTP that all systems will develop into Integrated Care Systems (ICSs) by April 2021 – the Sussex

Health and Care Partnership's strategic delivery plan, and the related technical submissions, will be a key driver of this.

There is a regulatory requirement from NHS England (NHSE) and NHS Improvement (NHSI) that systems develop plans for local delivery of the LTP, which includes providing a local response to each of the national commitments in the LTP.

From the Council

Sustainability and Transformation Partnerships/Integrated Care Systems are required to respond to the NHS Long Term Plan by mid November 2019. The requirement is that the responses are developed with full local engagement of stakeholders and therefore it is appropriate for the response to be considered and commented on by the Health and Wellbeing Board.

The NHS Long Term Plan includes a number of areas where changes to legislation are proposed to make it easier for Integrated Care Systems to work together effectively. The Plan does not refer to Health and Wellbeing Boards in relation to its proposals. There are also proposals to review statutory responsibilities in relation to Public Health services, commissioning responsibility for which currently rests with local authorities.

The Health and Wellbeing Board will need to keep the local response to the LTP under review and monitor progress in order to ensure that the implementation and delivery aligns with the agreed Health and Wellbeing Strategy and Joint Strategic Needs Assessment approved by the Health and Wellbeing Board.

Lawyer consulted: Elizabeth Culbert Date: 291019

3.2 Finance:
Financial Comments from the CCG
High level financial implications of establishing the Sussex Health and Care Partnership's strategic delivery plan, and of delivering our response to the LTP are set out in the report. Detailed financial planning at organisation and local system level will be worked up as part of the implementation and delivery process.

From the Council Finance Officer
This report provides an update on the NHS Long Term Plan. At this stage, this is a high level plan which, when accepted by NHS England, will then be developed into a delivery plan. Any changes in service delivery for the council will be subject to the recommissioning processes and will need to be delivered within the budget envelope available.

Finance Officer consulted: Sophie Warburton Date: 28/10/2019

3.3 Equalities

From the CCG
Consideration of equality issues has been integral to the Plan development process. The LTP response devotes a section to requirements for ensuring stronger action on health inequalities. Where required, Equality Impact Assessments will be undertaken in relation to specific service modifications as part of the detailed implementation processes.

From the Equalities lead of the Council
Consideration of all equality issues has been integral to the Plan development process. The LTP response devotes a section to requirements for ensuring stronger action on health inequalities. Where required, Equality Impact Assessments will be undertaken in relation to specific service modifications as part of the detailed implementation processes.

Brighton & Hove City Council supports the equalities approach outlined above by the CCG - with health inequalities being considered as an integral part of the wider Plan, in addition to a commitment to undertaking Equality impact Assessments to support the plan's practical implementation and delivery.

Supporting documents and information

Appendix1: Sussex Health & Care Plan with the three Area Based Plans

1) Brighton & Hove
2) East Sussex County
3) West Sussex

Full colour versions can be seen here:
https://www.seshealthandcare.org.uk/about-us/sussex-health-and-care-plan/

Sussex Health and Care Partnership

Strategic Delivery Plan



Response to the Long Term Plan

28th October 2019

DRAFT Version 17

Patient-centred Transformation Partnership Sussex Health Integration Sustainability Social care

Table of Contents

1. Executive Summary 4
   1.1. Our ambition 4
   1.2. Our strengths 4
   1.3. Addressing our challenges 5
   1.4. Our plans to deliver system priorities 6
   1.5. Delivery through collaboration 7
   1.6. Our Strategic Delivery Plan 8
2. Context: Our footprint and population need 9
   2.1. Our Sussex footprint 9
   2.2. Our population need 10
   2.3. Our progress to date 13
3. Our health and care strategic model to drive transformation 15
   3.1. Our strategic intent 15
   3.2. Our health and care strategic model 17
   3.3. Public engagement 24
4. Transitioning to our new model 29
   4.1. Sussex as an aspirant ICS 29
   4.2. Establishing place-based Integrated Care Partnerships 35
   4.3. Neighbourhood-based Primary Care Networks 38
   4.4. The role of Specialised Commissioning 45
5. Investing to deliver change: our financial framework 46
   5.1. Our route towards financial sustainability 46
   5.2. Our system's financial framework 48
   5.3. Developing system-wide financial assurance 49
   5.4. Developing payment reform options 49
6. Putting prevention at the heart of our plan 50
   6.1. Current state and challenges 50
   6.2. Key drivers 54
   6.3. Key priorities to delivery five-year vision 57
   6.4. Governance 65
   6.5. Interdependencies 66
7. Our transformation priorities 67
   7.1. Developing a new service model centred around place-based joined-up care 67

7.2. Improving cancer outcomes 81
7.3. Improving mental health outcomes 101
7.4. Delivering further progress on care quality and outcomes 109
8. Supporting our workforce 130
8.1. Current state and key challenges 130
8.2. Sussex workforce plan 130
8.3. Workforce strategic priorities – delivering the interim NHS People Plan 133
8.4. Strategic plan from 2020/21 to 2023/24 137
8.5. System approach to delivering our workforce priorities 138
8.6. Key assumptions 139
9. Supporting effective delivery: Our Sussex-wide enablers 141
9.1. Digitally-enabled care 141
9.2. Estates 162
10. Programme governance 171
10.1. Governance and monitoring delivery 171
10.2. Quality and assurance 172
10.3. Moving into operational delivery planning 176
10.4. Major risks and mitigating actions 179

1. Executive Summary

The Sussex Health and Care Partnership is a new footprint which serves a **large and varied population of 1.7 million people** and is responsible for **£4bn of health and care spending**, delivered by **over thirty thousand staff**.

It is a complex system with multiple providers, commissioners and partners. We are currently on the journey to transition from the **previous Sussex and East Surrey Sustainability and Transformation Partnership** towards our **new Sussex Health and Care Partnership**.

1.1. Our ambition

We aspire to have a responsive and adaptive system **co-designed in partnership with our Sussex population** around the outcomes that matter to them, providing sustainable care which suits the needs of our population. We will deliver this through an **integrated population health management approach** which segments our population based upon need, to provide the best possible care whilst ensuring that there is not unwarranted variation in outcomes.

We will take a holistic approach to supporting our population's health and wellbeing of mind and body in an integrated way. This will require new ways of working with Sussex health and social care organisations to determine the models of care that best suit our population, considering the wider determinants of people's health and care needs to develop an increasing role for the wider community and voluntary sector in addressing those needs. The role of the individual is critical in this and we will use the resources of our large and highly skilled staff to support our population to have the knowledge, skills and confidence to protect and manage their own health.

Our population health management approach will be planned and delivered collaboratively through organisation-agnostic Integrated Care Teams working within the community. The specific composition of teams will depend upon the need of the local area and the outcomes that matter to that population. These will involve existing clinicians and practitioners across organisations, with some additional roles including social prescribers, working together in a different way to deliver high quality, joined-up care. By making services responsive and flexible, we will address the priority areas for outcomes improvement which account for 75% of deaths and disability across our footprint. These include cancer, mental health problems and cardiovascular & respiratory disease, alongside our prevention priorities of smoking, obesity and alcohol.

1.2. Our strengths

Sussex has considerable strengths in how we deliver health and social care, which provide a clear platform upon which to build our system aspirations. We have demonstrable strengths across our footprint:

- The **East Sussex Better Together** programme has led the way for integrated service planning and transformation with both social care and health
- **Western Sussex Hospitals Trust** continues to be rated 'Outstanding' by the CQC
- **Sussex Community NHS Foundation Trust**, **Sussex Partnership NHS Foundation Trust** and **Brighton and Sussex University Hospitals** are rated 'Outstanding' in the 'Caring' domain

- **Queen Victoria Hospital** continues to be rated by patients as one of the country's top hospitals for quality of care
- **Sussex Partnership Foundation Trust** has led a strong Sussex-wide partnership programme approach for Mental Health that has resulted in winning funding for innovative new services
- 95% of our **GP practices** are rated good or outstanding
- Our **Ambulance Trust** continues to improve 999 services, recently receiving a CQC rating of 'Good' overall, including 'Outstanding' for Caring
- Across emergency and urgent care, our collaborative system-wide work to reduce hospital handover times and improve services for mental health patients have both been rated 'Outstanding'.

We have collectively delivered **amongst the most significant improvements in financial position nationally since 2017**, with a 2.4 percentage point improvement in overall surplus / deficit against a national background of declining performance. A significant proportion of contracts are already aligned incentive contracts for 2019/20 and we are exploring risk sharing models to stimulate delivery of our new models of care. The Partnership is committed to identifying innovative and benefit-sharing options to engage both providers and commissioners.

Some of our CCGs and providers have also successfully moved out of financial and quality special measures recently, demonstrating that across all of our system partners, providers and commissioners, Sussex has great strength and is continually delivering improvements.

Our current strategic planning has been rooted in a **strong commitment to developing our services in partnership with our staff, patients and the public**. Through our public engagement, we have heard from around 1,500 people in Sussex through a combination of open engagement events, focus groups and online surveys. This has included members of the public, patients, carers, people experiencing mental health problems, physical and sensory disabilities, people from diverse ethnic backgrounds, and former members of the UK Armed Forces, together with colleagues from voluntary and community sector organisations, partners and clinicians. We have undertaken extensive engagement across all partner organisations, with input from hundreds of staff across health and care.

1.3. Addressing our challenges

Alongside our considerable strengths and recent progress, we acknowledge that there are several challenges facing the delivery of sustainable services in Sussex, which we will address through our new ways of working.

To realise our ambition of providing sustainable care suited to the individual needs of our population, we **must tackle the financial challenge that our system faces**. The **current projected deficit** for NHS providers and commissioners in our Partnership is **£(74.4)m (2.7% of total commissioner spend) for 2019/20**.

Our "do nothing" financial challenge as a Partnership is a **pre-sustainability funding deficit of £(284.5)m (8.9% of total commissioner spend) in 2023/24**, driven by rising demand and cost inflation. Our financial planning will need to leave us headroom to meet constitutional standards, including revised access standards to be implemented from Spring 2020. In addition, we will face a

potential continuing workforce gap of 11.2% overall in 2023/24, representing 3,920 WTEs.

Realising our ambition will require us to **strengthen existing relationships between primary, acute, community and mental health services**, and to **expand our system governance to further reinforce relationships with local authorities**, including district and borough councils, and the voluntary and community sector.

At the neighbourhood level, **one or more of our 38 Primary Care Networks (PCNs) will bring together GPs to work with local community services, mental health, social care, pharmacy and voluntary sector teams**, to collaborate to provide integrated local health and care for patients and the population. This will enable patients to experience well-planned services, appropriate to their needs, and seamless pathways. PCNs will also be involved in the **planning, design and delivery of local services** and service improvement to improve health and outcomes in neighbourhoods.

To facilitate greater partnership working, we plan to have **three CCGs and three 'places' contiguous with local authority boundaries, working with neighbourhoods**. Each place will function as a **collaborative planning unit and transition to an Integrated Care Partnership (ICP)**, an alliance of neighbourhoods and sovereign providers that will bring together health and social care providers and commissioners. ICPs will support the delivery of acute and community care, hosting Integrated Care Teams with easy access to secondary care expertise and using a population health management approach to segment and actively plan services.

As a **future Integrated Care System (ICS)**, our Sussex scale system will build from local neighbourhoods to deliver those **functions that are best managed across the whole of Sussex**. This is likely to change over time as the ICPs develop and are able to address more of the issues at scale.

Our system reform will have to reflect the varying maturity of development within these proposed ICPs and amongst our PCNs, including the provision of additional support for organisational change and PCN development. In addition, we will work with our neighbouring systems in Surrey and Kent to ensure our planning and care delivery takes into account actual patient flows.

1.4. Our plans to deliver system priorities

Our strategy encompasses clearly articulated plans which are based upon our strengths as a system. The system strengths and our skilled staff will be key in delivering our system priorities and addressing the current and future challenges.

We will **work in a different way with the public** to collaborate to set outcomes and ensure that our population is at the front of the design of our new services. The Health and Care Strategic Model establishes this new method of service delivery which differentiates care delivery at neighbourhood, place and Sussex-wide level to ensure that all individuals receive the best care in the best environment.

Our staff working across primary, acute, community, mental health and social care will come together to support people to manage their social, physical and mental health and wellbeing. This allows the **places to focus on population health management and joined-up care through**

Integrated Care Partnerships and achieves the best outcomes across Sussex by working in partnership to deliver high quality specialist and complex services. Our model has been designed by clinicians and agreed by the system, based upon the themes raised by our local population as part of public engagement, and focuses upon the key building blocks of prevention, addressing the wider determinants of health and empowering individuals to manage their own health and care needs.

We will **deliver bespoke programmes of work** to address key issues and areas of unwarranted variation, including stroke, ageing, and learning disabilities & autism, with a **robust delivery and governance framework to ensure accountability for delivering outcomes**.

To **address our financial deficit**, our delivery plans will meet prescribed trajectories and we have developed a financial framework to help guide financial planning and contracting over the coming months. We will change the way that we assure financial performance and align this to a population health management approach to underpin our new health and care strategic model. Local authorities have also been included within the financial framework as a first step to further strengthening our relationships and developing integrated community services. We will work as a system to ensure we continue to deliver the best outcomes for public finances, using **evidence-based decision making to prioritise service transformation**.

Alongside detailed plans to **address our workforce gap and improve our future workforce supply**, we recognise the critical role our staff play in the delivery of our vision. We can only deliver these plans by maximising the workforce contribution to facilitate a shift in culture and ensure that health and care are everyone's responsibility. In turn, we will need to upskill our staff to achieve this, ensure our workforce are happy and healthy, and establish the role of our health and care structures as anchor organisations to influence the wider determinants of health. We know we need to go further to support our people and are prioritising plans to improve mental and physical health and wellbeing, promote flexible working, and provide continuing professional development opportunities including development of new roles and leadership capabilities.

As we **undertake this wide scale system reform and service transformation**, it is more important than ever to ensure we provide services of the highest quality, delivered with respect and compassion, and provide a positive care experience for our population. Our developing plans will all be assessed for their impact on quality of care and health inequalities, alongside ongoing performance monitoring of providers against standards and outcomes across patient experience, patient safety and clinical effectiveness. To further strengthen our quality assurance, we will ask our local population to identify the outcomes that matter to them and use these to monitor performance and develop targeted improvement interventions.

1.5. Delivery through collaboration

Collaboration across the ICS will provide the mechanisms needed to deliver our system priorities through service and partnership development. We have already made significant strides on our journey towards greater integration and development as an aspirant ICS, including:

- Convening a **transparent Partnership Executive Group** which includes representatives from all NHS organisations and county councils

- Aligning our new governance structures, including shifting towards a **single SRO and independent chair**
- Establishing **Primary Care Networks (PCNs) across Sussex**, with nominated Clinical Directors for each
- Assembling a **Clinical and Professional Cabinet** to provide clinical system leadership, with representatives from all NHS providers and commissioners, public health and primary care, who have collaborated to develop our health and care strategic model
- Ensuring that our **Finance Group** now operates as a **strong and effective vehicle for cross-system collaboration**, with an agreed finance, activity and workforce model
- Forming the **Acute Care Collaborative Network**, which will facilitate system-wide collaboration and transformation across Sussex.

Our ambition is to become a **'maturing' ICS by April 2020** supported by our status on the ICS Accelerator Programme. Despite our considerable strengths and recent progress, we recognise that a significant amount of work will be required to reach our goals, in particular around further defining our system architecture (including the development of ICPs and PCNs), reforming our commissioning model, establishing a Population Health Management approach and building a shared quality, performance and financial assurance system. We look forward to working with the regulator to enable effective deployment of our strategy, and strengthen how we work collaboratively as a system to deliver the strategic plan.

1.6. Our Strategic Delivery Plan

Our Strategic Delivery Plan lays out the specific proposals to deliver the ambition highlighted above, including:

- Further detail relating to our **health and care strategic model**, including descriptions of how the model will be delivered and be both clinically and locally-led
- Our **system-wide agreed financial framework**, which underpins our delivery
- Our **transformation priorities**, focusing specifically on those priorities set out in the **Long Term Plan** and identified in our **Population Health Check**
- **Comprehensive governance and clear mechanisms** for tracking delivery and monitoring progress against our priorities and the targets.

We are acutely aware that our Strategy Delivery Plan includes commitments to address our financial deficit, address our workforce gap, reform how our Sussex health and care organisations work together, transform patient pathways, and deliver the significant number of initiatives included within the Long Term Plan. Each of these are challenging to deliver in themselves but **together require profound and extensive system transformation**.

Successful delivery of all these commitments will require us **prioritise the reforms with the greatest impact across the system and to form new ways of working to provide the bandwidth to deliver**. As of October 2019, we are beginning forward planning to enable us to move directly into operational delivery planning. While our Strategic Delivery plan sets out what we want to achieve and the principles of how we will work together differently, our **operational planning will set out how we will achieve this and what needs to change to enable this**.

2. Context: Our footprint and population need

2.1. Our Sussex footprint

Our footprint is home to over 1.7 million people and our Partnership provides health and social care for these people at a cost of £4bn per year. Having recently undergone a reorganisation to change from the Sussex and East Surrey STP to the Sussex Health and Care Partnership, we now comprise seven CCGs, seven statutory providers (excluding GP providers), and three local authorities:

- Brighton and Hove City Council
- Brighton & Hove CCG
- Brighton & Sussex University Hospitals NHS Trust
- Coastal West Sussex CCG
- Crawley CCG
- East Sussex County Council
- East Sussex Healthcare NHS Trust
- Eastbourne, Hailsham and Seaford CCG
- Hastings and Rother CCG
- High Weald Lewes Havens CCG
- Horsham and Mid Sussex CCG
- Queen Victoria Hospital NHS Foundation Trust
- South East Coast Ambulance Service NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- West Sussex County Council
- Western Sussex Hospitals NHS Foundation Trust

We maintain our close relationships with providers First Community Health and Care and IC24, and continue to work closely with East Surrey CCG, Surrey and Borders Partnership NHS Foundation Trust, Surrey and Sussex Healthcare NHS Trust and Surrey County Council.

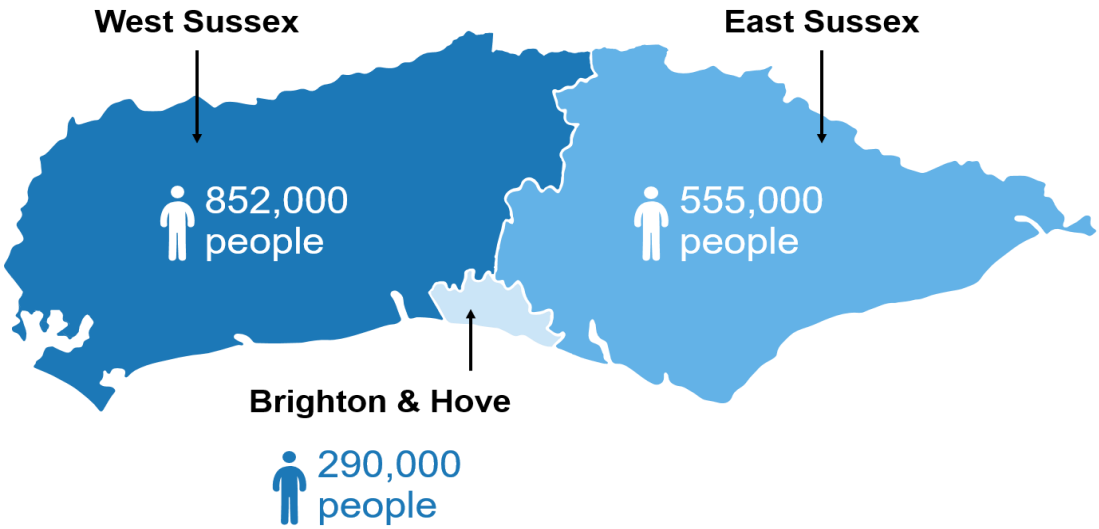


Figure 1: Our Sussex footprint and population

2.2. Our population need

We carried out a Population Health Check in 2018/19, which was developed by local doctors, specialists and clinicians to understand and describe the current state of health of the Sussex population. It also identified areas of concern and where the care provided was less than optimal. These concerns were also reflected by the public during our recent engagement process.

Our health profile, and hence priorities, are largely in line with the rest of the country. However, there are significant variations across our footprint in terms of socioeconomic status, health outcomes, environment and economic prosperity, which are often masked by averages.

The resident population across the overall area is projected to increase between 2016 and 2030, from a projected range of between 9.2% increase in the Central Sussex and East Surrey Commissioning Alliance south area (covering Brighton & Hove and High Weald Lewes Havens CCGs) to a 12.0% increase across Coastal West Sussex. The Over-85 group will see the largest increases, with population growth of between 32.5% and 42.1% predicted over the same time period.

Although the majority of our CCGs have a healthy life expectancy,[1] higher than the national average, this is not universal across our footprint. The variation in male healthy life expectancy is 6.6 years between the lowest and highest ranked CCGs (62.5 years in Hastings & Rother and 69.1 in Horsham & Mid Sussex). Hastings & Rother also has the lowest female disability-free life expectancy, at 64.1 years, compared with Horsham & Mid Sussex at 69.4 years.

Similarly, while Sussex is fairly affluent overall, there are pockets of significant social deprivation, notably along the coastal strip in Hastings, Brighton & Hove and Littlehampton, which rank within the most deprived areas in England.

We have a significant mental health need; severe mental illness is 5% higher than the national average and this represents around 25,000 people. We also have rates of dementia that are 25% higher than the national average, with significant concentrations of elderly populations within West Sussex in particular. The health and life outcomes for people experiencing mental health issues will continue to fall short of those of the general population unless we act to deliver the opportunities aligned with the Mental Health Five Year Forward View and the commitments of the Long Term Plan.

If we segment our population by age, we can see that there are a number of areas where focused effort will be required to ensure that everyone starts well, lives well and ages well across Sussex:

[1] Healthy life expectancy is an estimate of the number of years lived in ‘very good’ or ’good’ general health, based on how individuals perceive their general health. Disability-free life expectancy is an estimate of the number of years lived without a long-lasting physical or mental health condition that limits daily activities.

Children and young people

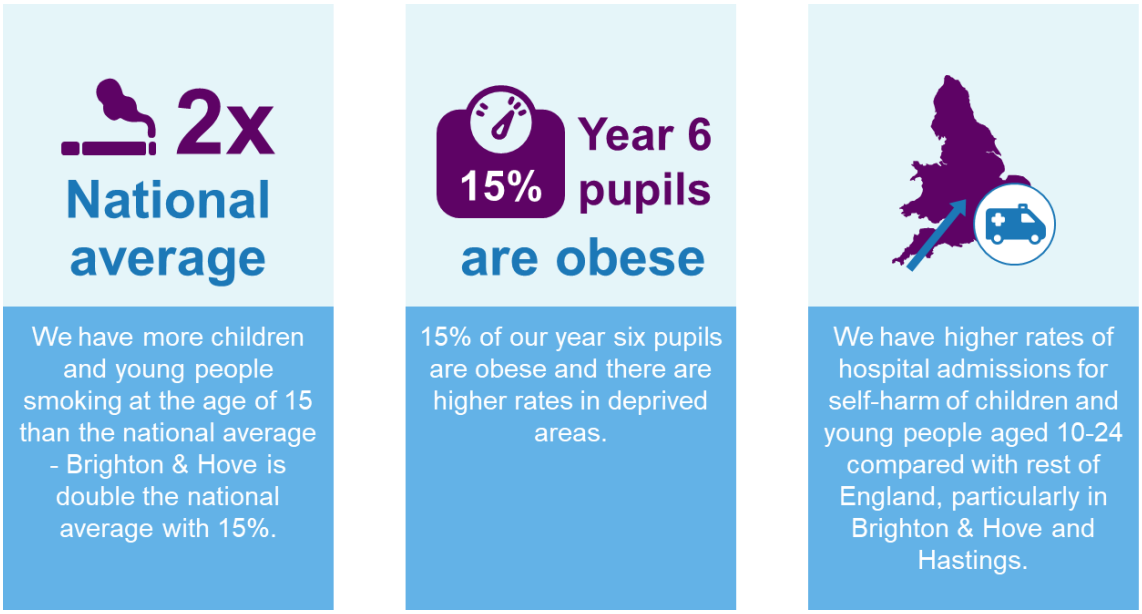


Figure 2: Our population – children and young people

Adults[2]

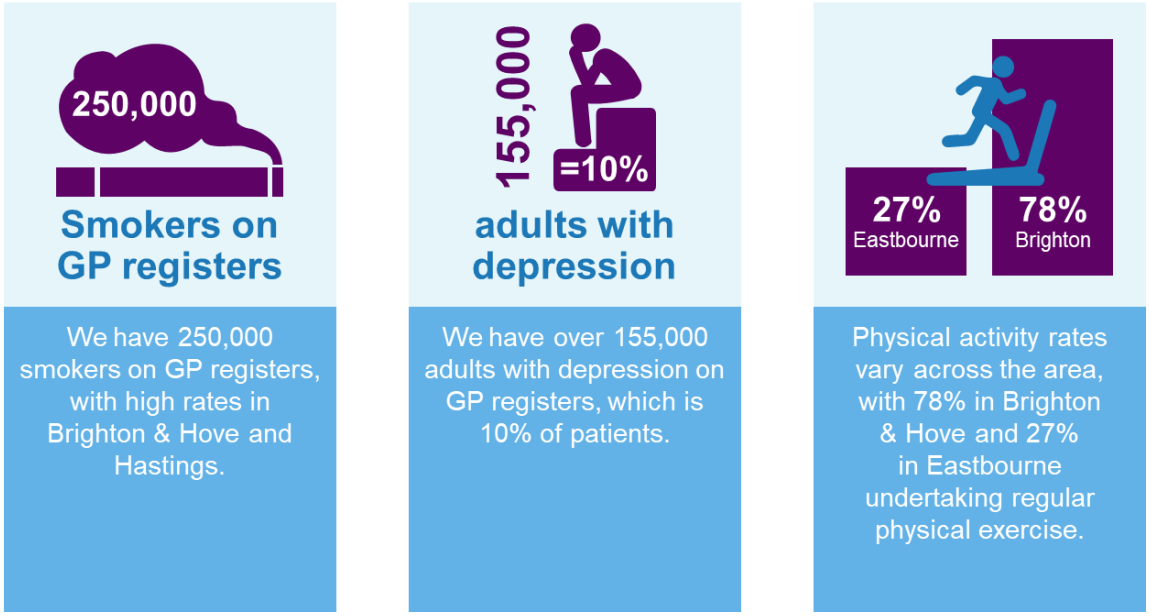


Figure 3: Our population – adults

[2] Physical activity rates are the percentage of adults estimated to undertake less than 30 minutes of physical activity per week

Older people

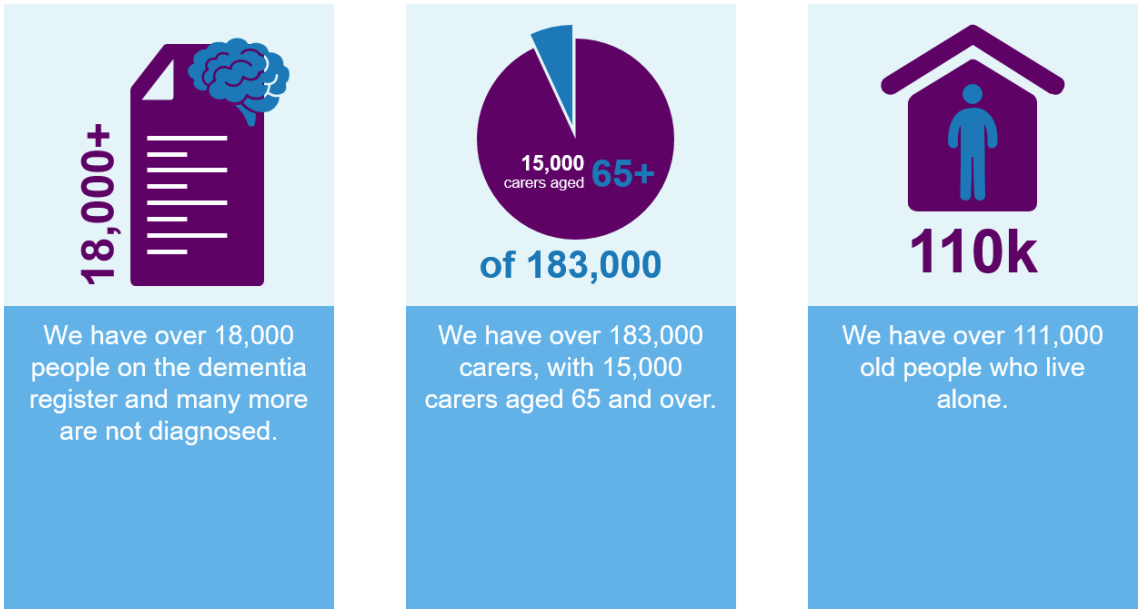


Figure 4: Our population – older people

Dying well

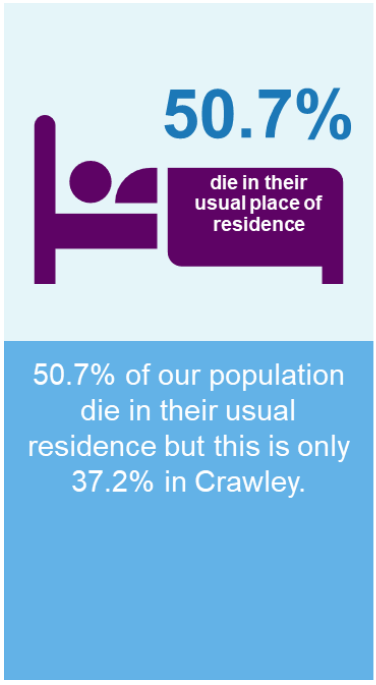


Figure 5: Our population – dying well

2.3. Our progress to date

Over the last 12 months Sussex has made considerable progress across financial, quality and performance metrics:

- We have reduced our deficit and improved our financial position, against a background of national decline in financial performance
- Our improvements have been recognised by the regulator, with Brighton & Sussex University Hospitals NHS Trust (BSUH) and East Sussex Healthcare NHS Trust (ESHT) lifted out of financial special measures and legal directions against three CCGs lifted
- A&E performance has also improved, in a context of national decline in 4-hour performance standards
- All providers have improved or maintained their CQC rating, with 86% of providers holding a 'Good' or 'Outstanding' CQC rating.

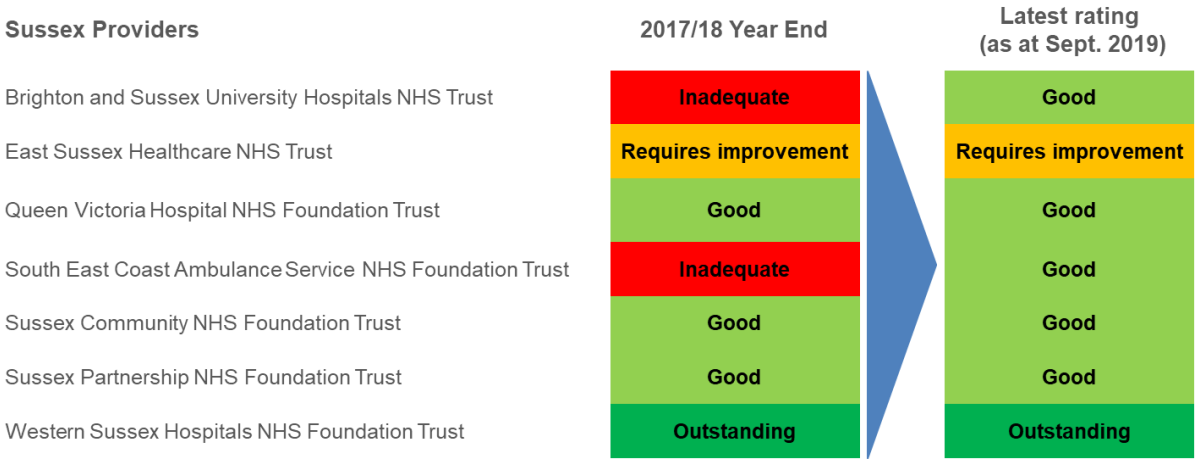


Figure 6: Our Sussex providers' CQC ratings

Against the backdrop of this success in finance, quality and performance, we have worked together across the system to develop more joined-up and clinically-led health and care services that have brought real benefits for patients. We have system-wide governance to align us on clinically-led health and care services:

- We have brought together our most senior medical and nursing leadership in the Clinical and Professional Cabinet to set our clinical priorities for the Partnership
- Our three places each have a Health and Wellbeing Board with representation from both NHS organisations and the Local Authorities, and have each produced a Joint Health and Wellbeing Strategy which sets out a clear vision, goals and ways of working to improve the health and wellbeing of all residents in Sussex
- We have over 30 clinical networks in Sussex, the most developed of which involve formal governance across system partners and commit to sharing activities and resources

- Organisationally, our CCGs have begun to work closely together under one management team which has led to benefits in how services are commissioned, how the limited resources are used, and how our CCGs work

- For the first time, a system-wide business plan has been developed and agreed for 2019-20, which will help ensure services are planned, delivered and paid for in a more consistent and effective way.

Our joint working is demonstrable on the ground, with two strong examples being practitioners from East Sussex Healthcare NHS Trust and East Sussex Adult Social Care now providing joint services for falls, frailty, crisis response and proactive care, and the Local Maternity System bringing together partners that support the provision of maternity services with the aim of improving safety, choice and more personalised care.

This greater emphasis on collaborative working will continue in the year ahead as we lay the foundations to ensure that our Partnership can develop into a maturing Integrated Care System (ICS) by 2020. There will be particular focus on ensuring all our partners can equally contribute to strategic work across Sussex and take more collective responsibility for managing resources, delivering NHS standards and improving the health of our populations.

3. Our health and care strategic model to drive transformation

3.1. Our strategic intent

Our Sussex Strategy Delivery plan responds to the needs of our local population, as identified in the Population Health Check, and envisions the future of health and care in Sussex.

Our Population Health Check described the current state of health of the Sussex population. It also identified areas of concern and areas where care provided was less than optimal. These concerns had also been identified by the public during our recent engagement process. Our Sussex Strategy Delivery plan aims to address these concerns and describe the future of health and care in Sussex.

Demand for our health and care services is rising due to a number of factors, including our growing and ageing population. The success of promoting longer life creates pressures as more people live for longer with one or more long term conditions, which necessitates a greater focus on social care in the community.

Historically, health and care services across primary care, community, mental health, social care and acute services have developed in relative isolation, and this has created barriers for our population. Now we have the **opportunity to integrate these services** and provide a coordinated end-to-end pathway for local people.

In addition, we have an increasingly engaged population; people want to be actively involved in their care and central to any decision making related to their wellbeing.

Whilst recognising the progress that we have made, this strategy responds to the needs of the Sussex population and describes how we will advance our model of care to deliver the highest-quality health and care services across Sussex.

Specifically, the strategy aims to:

- Strengthen the pivotal role of **prevention** from birth and the need to address the wider determinants of health. Our approach reflects the responsibilities of the whole system in addressing health and wellbeing – NHS, councils, police, education, voluntary sector, communities and individuals
- Recognise the importance of health literacy, **supporting people to have the knowledge, skills and confidence to self-manage**, protect their own health, and engage in treatment/care plans both independently and in partnership with professionals
- Address the need for responsive and flexible services, supported by effective use of **technology**
- Address the growing number of people with **long term conditions** who want to have a key role in managing their own care
- Improve **access to urgent care** for those who need a quick and effective response
- **Harness the potential of specialist services**, as well as breakthroughs in medical science and use of data, to maximise the benefits to our whole population.

3.1.1. Integrated commissioning

Wider determinants of health – including education, employment, income, discrimination, and safe and resilient communities – have a significant impact on the health of the Sussex population.

The local CCGs plan to strengthen local planning through organisational mergers, to avoid the fragmentation of the healthcare system. Integrated commissioning and care will be key to positive health and care outcomes and to effective delivery of this health and care strategic model.

Health and Local Authority commissioners will work together on delivery of health and care services, as well as on a programme to **address current inequalities,** in order to improve the health and wellbeing of our population from birth to old age.

3.1.2. Integrated care

Providers already work closely together across Sussex for the benefit of local people, and we will continue to develop these relationships. The bedrock of the Sussex integrated care model is close and effective working between primary and urgent care, community and mental health services, social care and the voluntary sector, to ensure that all individuals receive the best care in the best environment, with high quality care delivered at every level.

At the **neighbourhood level**, one or more **PCNs will bring together GPs to work with local community services, mental health, social care, pharmacy and voluntary sector teams**, to provide integrated health and care for patients and the population, alongside promoting quality and safety. This will enable patients to experience well-planned services, appropriate to their needs, and seamless pathways.

Integrated Care Partnerships (ICPs) will use the wealth of data that we have to understand the needs of, and actively plan services for the benefit of, our population. They will work collaboratively to co-design and deliver care pathway solutions to address unwarranted clinical variation and improve outcomes. Fundamental to this will be using integrated health and care records.

We will ask our population to identify the **outcomes that matter to them**, and use this information in assessing the performance of ICPs and to drive continuous improvement. We expect these outcome measures to inform the development of Integrated Care Teams. These teams will work with a **defined population segment** and account for outcomes that people have said matter to them.

To enable our teams to work well together, we will re-define our clinical, professional, operational and financial accountabilities to better reflect the scope of the Integrated Care Teams. Collaboration between urgent care and both neighbourhoods and ICPs will be fundamental to delivering the most effective and consistent outcomes at the appropriate level. Provision of integrated health and care records will also be central to successful delivery.

To deliver the Sussex Model outlined below, we need to work collaboratively with all health and care providers, who in turn must work closely with our commissioners. For our model to be successful, all organisations must be financially sustainable. Our financial framework must gradually increase the proportion of total resource spent on primary and community care without

undermining performance in the acute setting.

We are tremendously excited by this intent for health and care in Sussex, and look forward to working together with all of our colleagues to turn this intent into a reality.

3.2. Our health and care strategic model

Our future vision represents a new way of working for our system. We have developed our new clinically-led Health and Care Strategic Model, which sets out our new way of organising and delivering services. This section contains further detail on how each of these elements will work and come together to deliver our overall vision.

3.2.1. Three levels of the Sussex Health and Care Model

The Sussex Model is based upon the principle of health and care being delivered at three levels: neighbourhood, local area and Sussex. It is underpinned by the three fundamental building blocks: prevention, services that address the wider determinants of health, and enabling people to manage their own health and care.

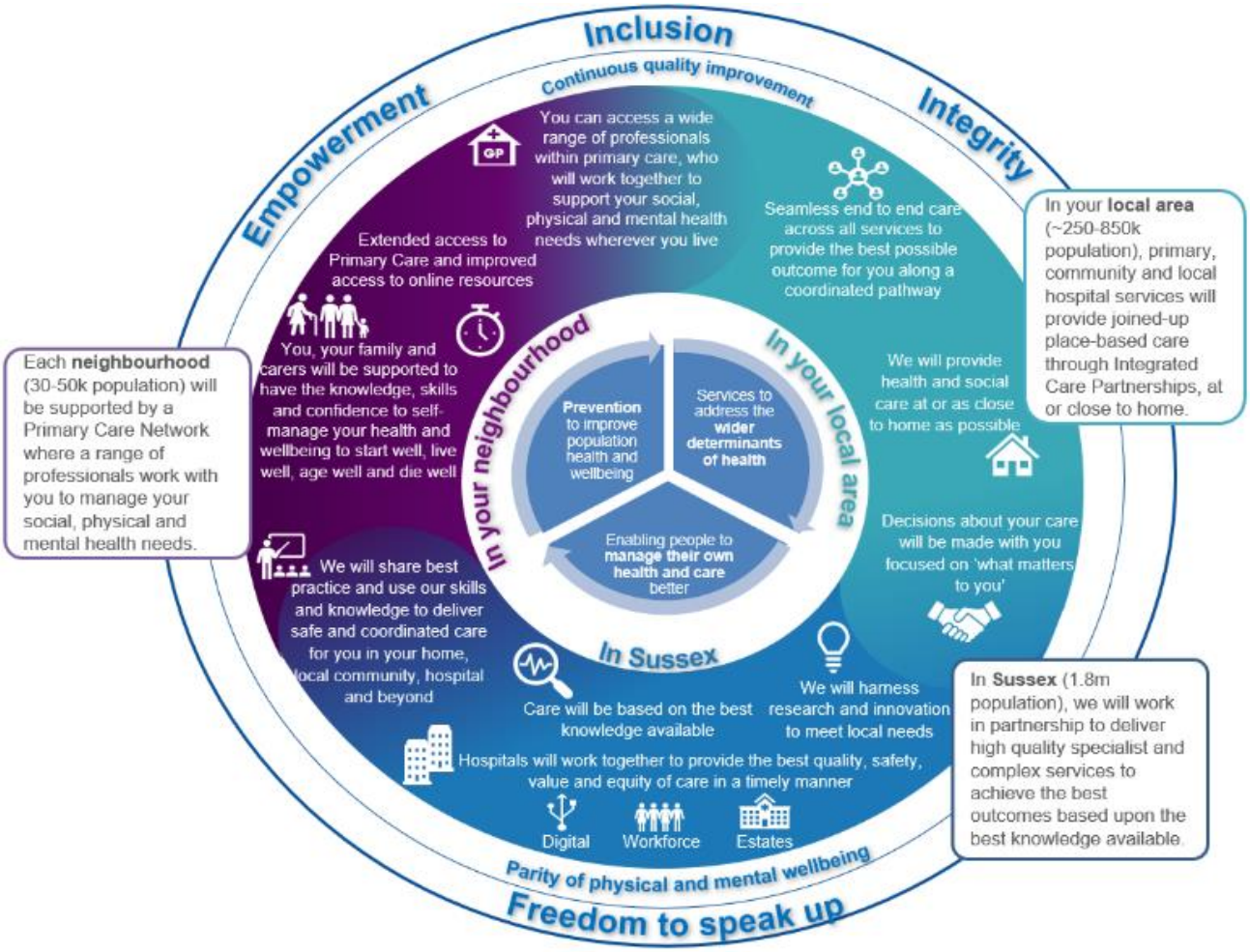


Figure 7: Our Sussex Health and Care Strategic Model

3.2.2. Three building blocks of the Sussex Health and Care Model

- The impact of a person's social circumstances and environmental surroundings, including employment and housing, and factors such as loneliness and isolation, influence the uptake of unhealthy behaviours which go on to account for a high proportion of disease and disability
- Many of the strongest predictors of health and wellbeing are **wider determinants of health which drive inequalities**. These include economic, social and environmental factors, which fall outside the scope of NHS and social care services
- The poorest and the most deprived people are more likely be in poor health, have lower life expectancy and have a long term condition or disability. Some groups such as BAME, LGBT+, people with special educational needs and disabilities, people with long term mental health problems and carers, etc. may require more intensive support and additional help to access services



Figure 8: The three building blocks of our Sussex Health and Care Strategic Model

- The four unhealthy behaviours of smoking, alcohol misuse, poor diet and physical inactivity, along with social isolation and poor emotional and mental wellbeing, are responsible for at least a third of ill health and are amenable to cost-effective preventative interventions
- Individual service prevention interventions improve health and wellbeing, and reduce inequalities. They also build stronger and more resilient communities and places which **support people to maintain independence, make heathier choices, and manage their own health and wellbeing** across the course of their lives. These are important components of a whole system approach to prevention across the NHS, Local Authorities, the voluntary sector, community groups and wider stakeholders.

How will services be provided?

These building blocks will be at the centre of our approach to designing health and care services, including:

- Engaging the population in co-design to identify need, shape services and to be involved in implementation
- Using data and technology to empower people to manage their own health and care, including online access to their records, online information and consultation, and direct appointment booking into different care settings
- Providing access to advice and support for the whole population to keep themselves well
- Increasing the use of social prescribing to enable personalised solutions for individuals, and improved integration of clinical and non-clinical services
- Giving the population direct access to a broader range of health and social care providers, for example clinical pharmacists and first contact physiotherapists.

3.2.3. Your neighbourhood

Each neighbourhood will be supported by a Primary Care Network (PCN), where primary and community teams work with individuals to look after their health and wellbeing.

How will it work?

- Community and other local services will be designed around neighbourhoods to ensure optimum integration of care – bringing social, physical and mental health together and delivery closer to home. PCNs will work with social care and the voluntary sector, as well as neighbourhood health services, to coordinate and integrate delivery.
- Each neighbourhood will be supported by the equivalent of 10-18 additional staff by 2023/24 through the new GP contract.[3] Expanded neighbourhood teams will comprise a broader range of staff including clinical pharmacists, physician associates, first contact physiotherapists, first contact community paramedics, community geriatricians, dementia workers, mental health practitioners and social prescribing link workers.
- We will support the physical and mental health of the local population by using data and involving local people and their feedback to appropriately target our services, build an in-depth understanding of health needs and inequalities, and develop multi-disciplinary, cross-sector teams to take responsibility for these needs, e.g. when delivering social care.
- PCN teams will be supported by easy access to and partnership with local hospices and specific secondary care expertise.

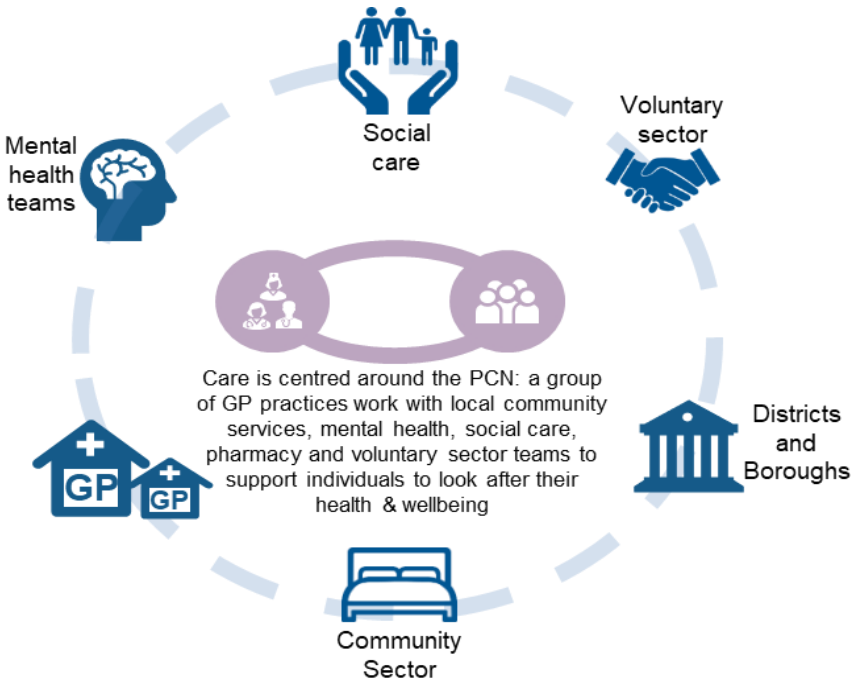


Figure 9: Neighbourhood services

[3] This is based on 20,000 additional staff promised to PCNs across the country through a new Additional Roles Reimbursement Scheme

What services will be provided at this level?

Multi-disciplinary teams will provide a range of joined-up services including:[4]

- Structured medications review and optimisation
- Enhanced health in care homes
- Anticipatory care requirements
- Personalised care
- Supporting early cancer diagnosis
- Cardiovascular disease prevention and diagnosis
- Tackling neighbourhood inequalities
- Managing clinical variation
- Extended hours access to primary care
- Integrated home visiting
- Social prescribing
- Advice, support and signposting for common mental health conditions
- Palliative and end of life care.

3.2.4. Your local area



In the local area, primary, community and local hospital services will provide joined up, place-based care through Integrated Care Partnerships, at or close to home.

How will it work?

- We will redesign services around individuals' holistic needs so that they can move seamlessly between primary and community health and social care, and local hospital services in a timely and efficient manner.
- Where it is safest and most effective, we will design clinical services around targeted populations at a local area level, seeking to deliver more care at home or in the local community.
- Integrated Care Partnerships (ICPs) will take responsibility for actively planning services for the benefit of the population, segmented by health and care needs, whilst ensuring that there is not unwarranted variation in outcomes, e.g. with consistent urgent care models. This will be undertaken in close collaboration with the public.
- ICPs are partnerships of "sovereign" providers, including Local Authorities, acute hospital trusts, community services and other providers within a Primary Care Network, that deliver end-to-end healthcare. This involves optimising whole care pathways, allocating resources against outcomes for the local population, and addressing local health inequalities.
- These partnerships will lead to integrated care teams, whose composition will depend upon the need of the specific local area and the outcomes that matter to that population.
- There will be ongoing work to understand how relationships will be further built between PCNs, local commissioners and providers to effectively manage activity flows.

What services will be provided at this level?

- Services related to **population health and wellbeing** – e.g. smoking cessation and antenatal clinics – will be tailored to local needs
- **Community health and care services** will be organised locally – including rapid response teams, reablement & rehabilitation, and other proactive approaches
- We will manage local provision of musculoskeletal, cardiovascular and falls/fragility services to **reduce unwarranted variation** in care outcomes, specifically in those areas identified in the Population Health Check
- ICPs will shift care settings to this local level where this is the best option
- ICPs will also provide a range of other functions best delivered at this local level, such as medicines management, clinical training & education, emergency planning, effective use of technology, and palliative care
- Managing demand and flow in urgent care through NHS111-CAS. This will be delivered in collaboration with ICPs to support consistency.

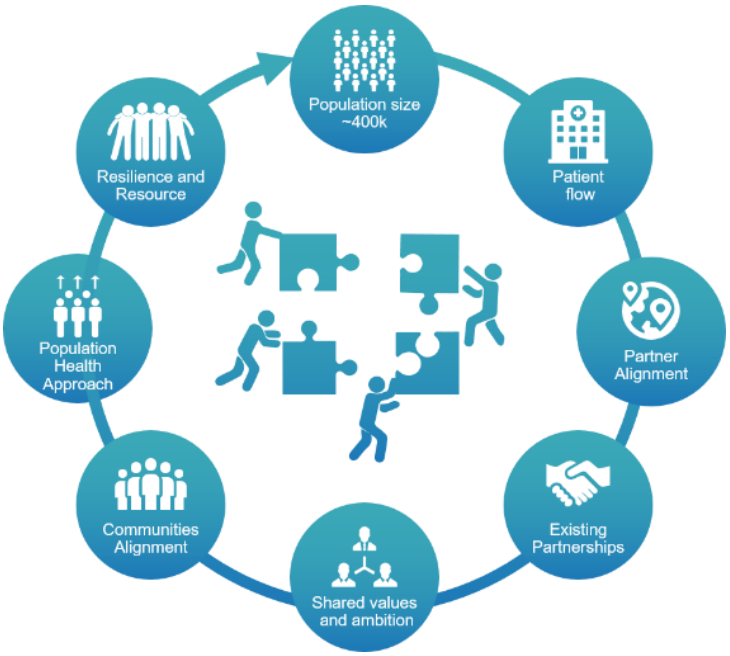


Figure 10: Features of Integrated Care Partnerships

3.2.5. In Sussex

In Sussex, we will work in partnership to deliver high quality specialist and complex services to improve outcomes and reduce inequality.

How will it work?

- Complex services will be planned and managed collectively across Sussex for our population
- Our health and care professionals will work together to share best practice and deliver the best and safest care to enable our population to 'start well, live well, age well and die well'
- The Sussex system will support Primary Care Networks to manage our population's needs on a larger scale through clearly managed advice and guidance arrangements for interacting with more specialist services and a pivotal role in the networked model for urgent care
- The Sussex system will deliver better services for better value through collaborative financial management, effective financial frameworks and management of other supporting services
- Health commissioners will work closely with Local Authority commissioners to develop a programme to improve health and wellbeing, and to reduce inequalities on a Sussex-wide scale
- The Sussex system will use local data to build a single view of multiple records, in line with LHCR developments.

What services will be provided at this level?

- Clinical networks will provide clinical leadership across the region.
- Sussex has developed a consistent and strategic networked model for delivering urgent care that collaborates closely with ICPs and PCNs.
- Lower volume specialist services which require from larger population catchments and co-location will be managed and delivered at a system level across Sussex. These services include Major Trauma, Plastics and Burns, Hyper-Acute Stroke and Thrombectomy, Neonatal and Specialist Paediatric Care, Neurosciences, Cardiac Surgery and Specialist Cardiology, Renal services, some Cancer modalities and Specialist Rehabilitation.
- Clinical services such as Mental Health provision and the Local Maternity System will coordinate and set strategy at a system level to ensure high quality services across Sussex and support research and education.
- Specialist centres will continue to be developed for more complex services. This will promote collaboration between clinicians to improve the quality of care and will increase value for money through economies of scale gained from partnership working. This will accelerate the development and uptake of innovation to support our system's needs.
- System wide management of essential supporting services, including digital, workforce and estates, will deliver continuous quality improvement.
- To enjoy the full benefits of technology, all our systems will need to work together and share information. This digital compatibility will help deliver more efficient care through access to online appointments for primary care, transformation of outpatient services, and roll-out of integrated health and care records.

3.2.6. Benefits for local people and for professionals

People in Sussex will benefit from equitable access to integrated care through:

- Improved, equitable access to high quality, safe and joined-up care, e.g. through patient access routes such as NHS111-Clinical Assessment Service (CAS)
- Access to support from the health and care professional with the most appropriate skills for their specific needs
- Health and care tailored in a more personalised way, to take account of neighbourhood diversity and to maintain services at or as close to home as possible, for example supporting more personalised end of life choices
- Empowerment to improve their own health and wellbeing, to 'start well, live well, age well and die well'
- Better availability of non-clinical solutions – e.g. preventative care to improve health and wellbeing
- Access to integrated health and care records
- Easier interactions with health and care services through technology-based solutions
- Access to primary care extended hours in the evening and at weekends
- More integrated support for multiple health conditions
- Enhanced support in care homes to ensure safe and high quality care.

Professionals will benefit from more collaborative and proactive ways of working, and effective tools and processes to enable them to deliver consistent and high quality care through:

- Greater professional satisfaction, with reduced burnout and improved retention, will help attract people to work in the NHS in Sussex
- Principles of inclusion, integrity and empowerment will be central to all activity
- Integrated and collaborative working with health and care colleagues will create opportunities for learning, uptake of innovation and providing more seamless care
- Improved health and wellbeing in Sussex, and reduced inequalities, will arise from encouraging preventative approaches across the system and empowering people to self-manage their conditions
- Professionals will have access to an integrated care record to facilitate these new ways of working
- The workforce will be adequately resourced, contain a diverse skill mix, and be sustained through effective succession planning
- Standardised systems, processes and approaches across the local area will help with delivering more consistent care
- There will be opportunities to co-design pathways and delivery of local services at scale
- Safe and positive environments will allow all professionals the freedom to speak up and to be heard.

3.2.7. Underlying principles

A set of underlying principles will guide how we deliver and organise health and care differently – in neighbourhoods, local areas and Sussex-wide.

Principle type	Principle	Rationale
Deliver health and care differently	Fewest medical miles	People prefer to have their care delivered close to home where possible. Information should flow between providers so that people do not have to travel long distances for care.
	Access to the right person or advice first time	Seeing the correct professional first time leads to quick, safe and efficient advice or treatment
	Timely provision	Services should be delivered in a timely manner that also manages demand and expectations
	Ensure appropriate movement of people across the system	When people move across providers in the system, it should only happen where necessary and should be managed effectively
Organise health and care	Reduce inequality	People, wherever they live, must have the same opportunity to lead a healthy life. To tackle inequalities, we must give more intensive support to those who are

Principle type	Principle	Rationale
differently		at greatest risk of poor health and may need additional help to access services.
	System integration	As systems increasingly come together, we need to think beyond discrete entities and create end-to-end pathways
	Incentivise quality outcomes	Commissioning for value incentivises the delivery of high value services, measured against a diverse set of metrics co-produced with patients which reduces variation
	Maximise quality through reducing variation	For every defined intervention by a practitioner, we should maximise quality by targeting the efficient delivery of high value, evidence-based care pathways
	Digital compatibility	Digital solutions should be developed in ways that make information sharing possible across the system
	Partnership working	Health and social care working in partnership across Sussex will deliver the best quality and safety of care in a joined up environment

3.3. Public engagement

3.3.1. Public contribution to this strategy

Over the last three years, a significant amount of work has been undertaken to ensure our populations have been involved in helping to shape the planning and provision of local health and care services across Sussex. This has been done primarily through two engagement initiatives – *The Big Health and Care Conversation* and *Shaping Health and Care*. These engagement mechanisms provided people with the opportunity to discuss how services and processes could be improved, and also to highlight their experiences and issues that needed to be taken into account with future planning and organisation of services.

This feedback helped develop the local transformation plans that have formed the basis of the West Sussex, East Sussex and Brighton & Hove place-based plans in Appendices B,C and D. Additionally, this public engagement and feedback informed the development of the system-wide Population Health Check that was published in January 2019 and provides the evidence base by which this strategy has been developed.

Following the publication of the NHS Long Term Plan in January 2019, further public engagement took place across health and care organisations to ensure our communities had the opportunity to respond to the national ambitions and expectations set out in the plan and to discuss how it could be brought to life across local populations.

The engagement was badged under the title 'Our Health and Care…Our Future' and was framed under the topics that made up the FUTURE acronym:

Facing up to our challenges
Understanding our needs
Transforming our services
Unjustified differences in our care
Resources for our services
Equity for our people

Framing the discussions in such a way provided people with clear and understandable topics to discuss, and ensured that conversations could be broad and span beyond just healthcare. Our public were informed throughout the engagement process that their feedback would be used to help shape this strategy and that we wanted to build on, and not replicate, previous conversations that had taken place as part of our ongoing engagement.

The engagement was carried out in two phases. During February to May 2019, we focused on geographical locations and spoke to communities in 12 different locations across Sussex. Phase two focused on targeted engagement with individuals and groups we had not spoken to in phase one, and who historically have not had regular opportunities to input their feedback into health and care services.

In total, we had almost 1,000 conversations with people across Sussex and collated a significant amount of feedback. A summary of the key themes of this feedback and how we have responded to it is outlined below. A full summary of the feedback and how it has been used to shape the strategy can be found in additional documents.

Alongside the qualitative feedback collated, we also carried out a prioritisation exercise across our communities to gain a greater understanding of what areas of the NHS Long Term Plan our population found most important to them. The results of this are outlined below and have been used to provide greater evidence for the actions and strategic direction set out within this strategy.

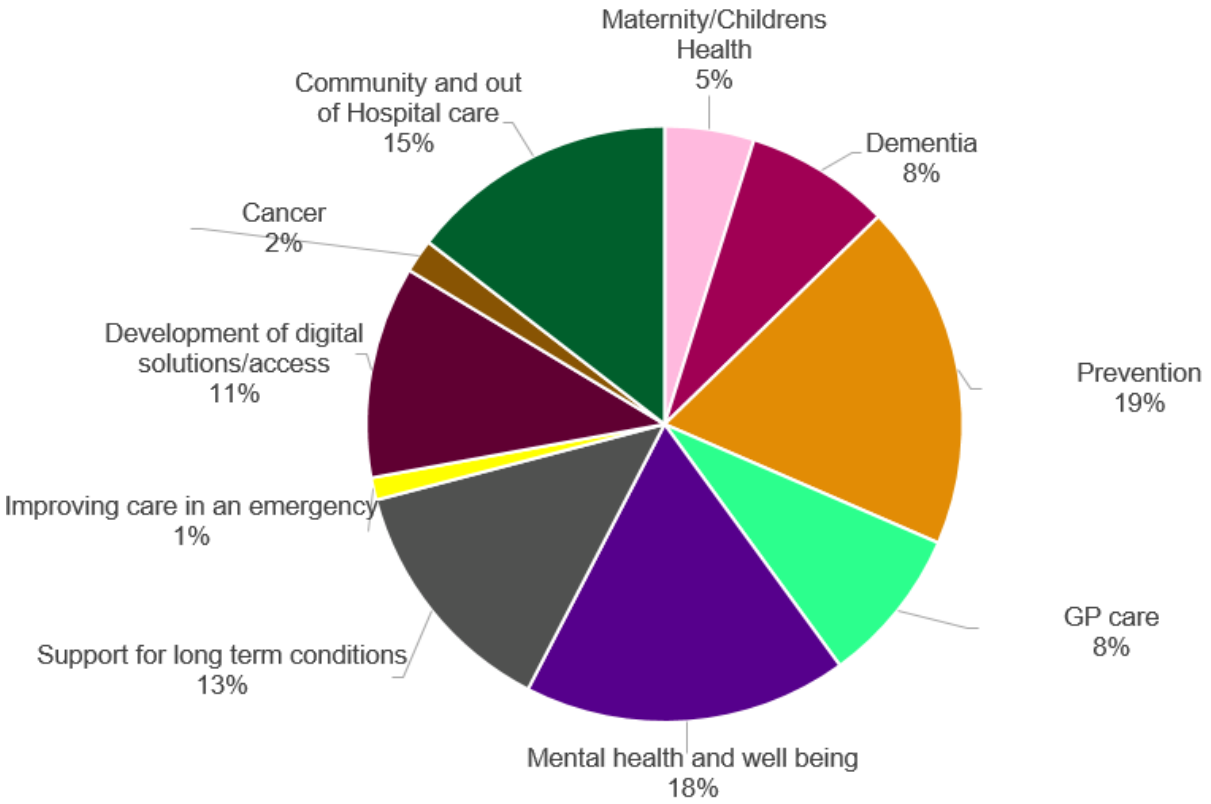


Figure 11: Public opinions on areas of the Long Term Plan most important to them

In addition to the public engagement carried out by our health and care organisations, NHS England commissioned Healthwatch to support systems to capture the views of the public living across their local areas.

Our three Healthwatch organisations, East Sussex, West Sussex, and Brighton & Hove, worked together to carry out a survey and hold focus groups to gain feedback on the NHS Long Term Plan. Almost 650 responses were received on what mattered most to people about their care and support needs. This feedback has been considered as part of the development of this strategy and is summarised in a supporting document.



Key themes:

- Patients should be supported to **play a more active role** in their care incl. **shared decision making**
- **Greater focus on prevention** is needed with info. available through varied routes
- **Community initiatives**, incl. social prescribing, should be seen as a viable alternative
- Moving **investment into primary and community care** will help support local provision of services
- **Holistic approach to wellbeing** should join up services incl. housing, transport, health and social care, e.g. at 'Health Hubs'
- **Mental health** should be prioritised and services improved
- **Integrated health records** are needed to enable joined-up care
- **Workforce capacity** is impacting experience of care and needs to be addressed urgently

Our response:

- Our new operating model is built with **prevention and self-management at the centre**
- Through the use of Primary Care Networks, **community and voluntary services will play a greater role** in provision of services
- Population Health Management models will help **prioritise prevention and allow funding to move to support** these initiatives
- Local health and care services are becoming **more integrated** through ICPs and **forming collaborative links to local authority** services
- **Mental health is a priority area**, with £XX investment ringfenced over the next five years
- Development **of comprehensive care records** are a priority to enable our digital transformation
- **New workforce models**, incl. new roles are being developed

Figure 12: Key themes from engagement 'Our Health and Care…Our Future'

3.3.2. Ensuring ongoing public involvement

Our local health and care system is committed to developing a strategic model that is shaped, developed and maintained with the sustained and ongoing input and involvement of our populations. We want to create a system where public engagement and involvement is institutionalised within the functioning of our health and care organisations and fully embedded in how services are planned, provided and paid for.

To ensure this aspiration becomes a reality, during 2020-21 we will work with Healthwatch, the community and voluntary sector, and our communities, to develop a new integrated model of public engagement. This model will involve:

- A new framework for engagement that describes what good public involvement looks likes at a strategic and local level
- A new way of working across our three Healthwatch organisations to strengthen how the patient voice can be heard across the health and care system
- Mechanisms by which public feedback can be better captured and shared to inform the work of all health and care organisations across the system
- A governance framework for partnership involvement that ensures two-way engagement across our neighbourhoods, communities, places and Sussex
- An agreed framework and principles for achieving co-production, co-design and representation in a meaningful and productive way across the system
- Greater transparency and openness in the work of health and care organisations across the system and developing Integrated Care System
- Co-production of our agreed outcome sets with our populations
- Embedded public and patient involvement and engagement within our continuous improvement framework.

3.3.3. Communicating and ensuring engagement with the strategy

Date	Action	Details
28 October	• First draft published for comment on the Sussex Health and Care Partnership website • First draft of strategy shared for comment with members of the public and stakeholders who attended previous engagement events • Stakeholder letter to system partners	• Feedback form will be available for comment for two weeks – closing on 8th November
2nd December	• Full final document published • Summary document published	• The document will be fully designed • The document will be written in plain English and provide a Sussex narrative for the plan • They key areas of work and changes will be summarised individually to

Date	Action	Details
	• Summaries of key areas • Easy read version • Engagement document	provide scope for discussion • An easy read version of the plan will be produced to ensure full accessibility • A supporting document will be published summarising the engagement that has taken place, the feedback themes and how they have influenced the plan
January 2020 onwards	• Communications and Engagement Plan	We are developing a full post-publication plan which will include: • Communications campaign to bring the strategy to life • Communications campaign around key business transformational work • Public, clinical engagement and co-production/design programmes

4. Transitioning to our new model

The Sussex Health and Care Partnership is a new and relatively complex footprint with many considerable strengths from which we can build our system aspirations.

Our new Health and Care Strategic Model and the guidance on ICSs, ICPs and PCNs set out in the Long Term Plan provide an opportunity for fundamental system reform. We will use this opportunity to form new ways of working and provide the bandwidth to deliver the significant number of initiatives included within the Long Term Plan.

4.1. Sussex as an aspirant ICS

Collaboration across the ICS will provide the mechanisms needed to deliver our system priorities through service and partnership development.

DRAFT

We have already made significant strides on our journey towards greater integration and development as an aspirant ICS. The figure below shows our current position against the five domains of the ICS maturity matrix.

	Current position
System leadership, partnerships and change capability	• System leaders signed up to working together formalised through a signed contract agreement • Clear shared vision developed by the Clinical and Professional Cabinet, with representation from all NHS providers and commissioners, public health and primary care • Transparent, collaborative governance led by the Partnership Executive Group (members from provider and commission Executives, Local Authorities and senior clinicians), a single SRO and independent chair • Core Sussex programme team funded by contributions from partner organisations
System architecture and strong financial management and planning	• Strategic model designed around delivery of services at neighbourhood, place and system level • Plans for commissioning reform in place, transitioning to 3 CCGs contiguous with local authority boundaries • System-wide plans for workforce, estates and digital infrastructure with some early implementation • History of successful joint financial management, currently transitioning to a new financial framework and system of financial assurance
Integrated care models	• Established and ongoing programme to address unwarranted clinical variation • Plans in place to transition to population health management models • Early development of a new strategic model to deliver the LTP commitments with horizontal and vertical integration
Track record of delivery	• Significant improvement in overall financial improvement from 17/18 to 18/19 with two Trusts out of financial special measures and legal directions removed from three CCGs • Widespread improvement in care quality with two providers moved out of 'inadequate' and three rated 'outstanding' by the CQC
Coherent and defined population	• Geographical footprint co-terminous of two county and one city council – developing CCGs and ICPs aligned to the boundaries of a single local authority • Patient flows not fully aligned to local authority boundaries and plans being developed to manage this

Our ambition is to become a 'maturing' ICS by April 2020, building on our strong foundation in collaborative, integrated partnership working. This system working will be supported by and further developed through the ICS Accelerator Programme that is already in place.

We recognise that significant work will be required to reach our goal and develop as an ICS, building on our considerable strengths and recent progress. Our priority areas include:

1. **Developing and embedding our new system model**; this includes our overall ICS operating model as well as the development of ICPs and PCNs
2. Reforming our **commissioning model**
3. Codifying and implementing a **Population Health Management approach** that will enable us to focus on our three building blocks of prevention, addressing the wider determinants of health and enabling individuals to better manage their own health and wellbeing
4. Supporting **collaborative delivery of the LTP commitments**
5. Building a **shared, robust financial framework and financial assurance system** (see section 5 for details).

Our future ICS will maintain an overall assurance role for the Sussex health and care system; provide a forum for leadership, strategic oversight and collective decision making; and set the strategic direction and support the operational planning required to achieve this. The ICS will continue to plan and commission specialist services collectively, using clinical networks and building on existing clinical improvement, as well as facilitating collaboration and joint planning on enabling functions including finance, workforce, digital, estates and quality assurance.

In the transition phase to becoming an ICS, priority transformation programmes will continue to be overseen and monitored at a system level. As the places transition to becoming ICPs, greater system responsibility will transition from the ICS to be managed through the ICPs, with the ICS retaining an overall assurance role.

4.1.1. Developing and embedding our new system model as a future ICS

As a future ICS, we plan to have three CCGs and three ICPs contiguous with local authority boundaries, working with neighbourhoods. Within each neighbourhood, one or more of our 38 PCNs will bring together GPs to work together with local community services, mental health, social care, pharmacy and voluntary sector teams, to provide integrated health and care for patients and the population. This will enable patients to experience well-planned services, appropriate to their needs, and seamless pathways. Together our services will ensure all individuals receive the best care in the best environment, developing new models of care at every level.

Our system reform will have to reflect the varying maturity of development within these proposed ICPs and amongst our PCNs, including the provision of additional support for organisational change and PCN development. In addition, we will need to work with our neighbouring systems in Surrey, Kent and Hampshire to ensure our planning and care delivery takes into account actual patient flows. Further detail of this support is shown in sections 4.2 and 4.3.

An overview of our system reform milestones is shown below. These are current expectations which will be confirmed once the programme is underway.

DRAFT

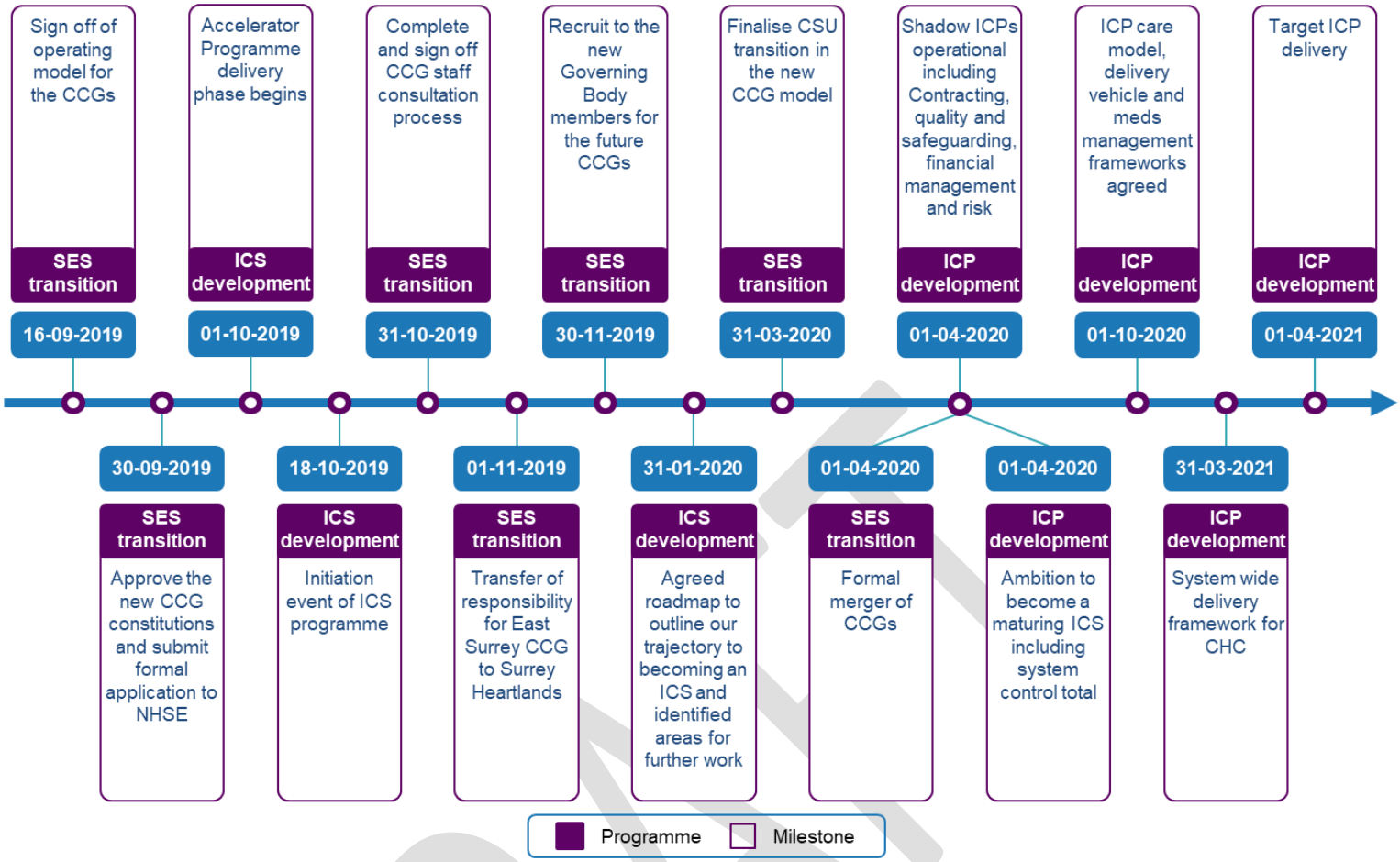


Figure 13: Key system reform milestones

4.1.2. Reforming our commissioning model

Through our Commissioning Reform Programme, we will foster collaboration between health and care commissioners, working across traditional boundaries to commission for improved population health outcomes, a reduction in health inequalities and improve collaboration and partnership working between CCGs and local authorities.

Our footprint has undergone significant change in recent months, transitioning from the Sussex and East Surrey STP to the Sussex Health and Care Partnership, following the move of East Surrey CCG and the associated providers to join Surrey Heartlands ICS in July 2019.

We have used this change as an opportunity to review our boundaries and the local commissioning landscape. Our seven CCGs have agreed to re-align to reflect local authority boundaries, becoming West Sussex, Brighton & Hove and East Sussex CCGs. The go-live date for the new, expanded CCGs is expected to be April 2020, with the application and implementation processes running from now to March 2020.

To support a smooth transition, there will continue to be a single Accountable Officer and shared executive management team across all CCGs, responsible for ensuring consistency of commissioning decisions and streamlined arrangements. Each of the new CCGs will also have a single Managing Director focused on local partnerships and delivery.

4.1.3. Codifying and implementing a Population Health Management approach

Population Health Management (PHM) has been recognised in the NHS Long Term Plan as key to delivering a sustainable health and care system and improving the lives of the population.

New data analytic tools and digital technologies are helping make PHM a reality, by helping to identify risks and stratify patient populations, improving the speed and accuracy of diagnostics, and designing personalised treatment plans. Successful implementation of PHM requires a combination of:

- **Behavioural change** from both health care providers and patients to focus on prevention, with support to self-manage and population segmentation tailored according to the individual's Patient Activation Measure, utilising an array of analytics, technologies and communication tools
- **Proactive identification and monitoring of high-risk patients**, and equitable access to evidence-based medicine, focusing on prevention and treatment and on improving function and wellbeing for individuals
- **Realignment of funding flows and incentives** to encourage staff to work differently across care settings, underpinned by an appropriate outcomes framework.

Our emerging approach to PHM is described in the figure below.

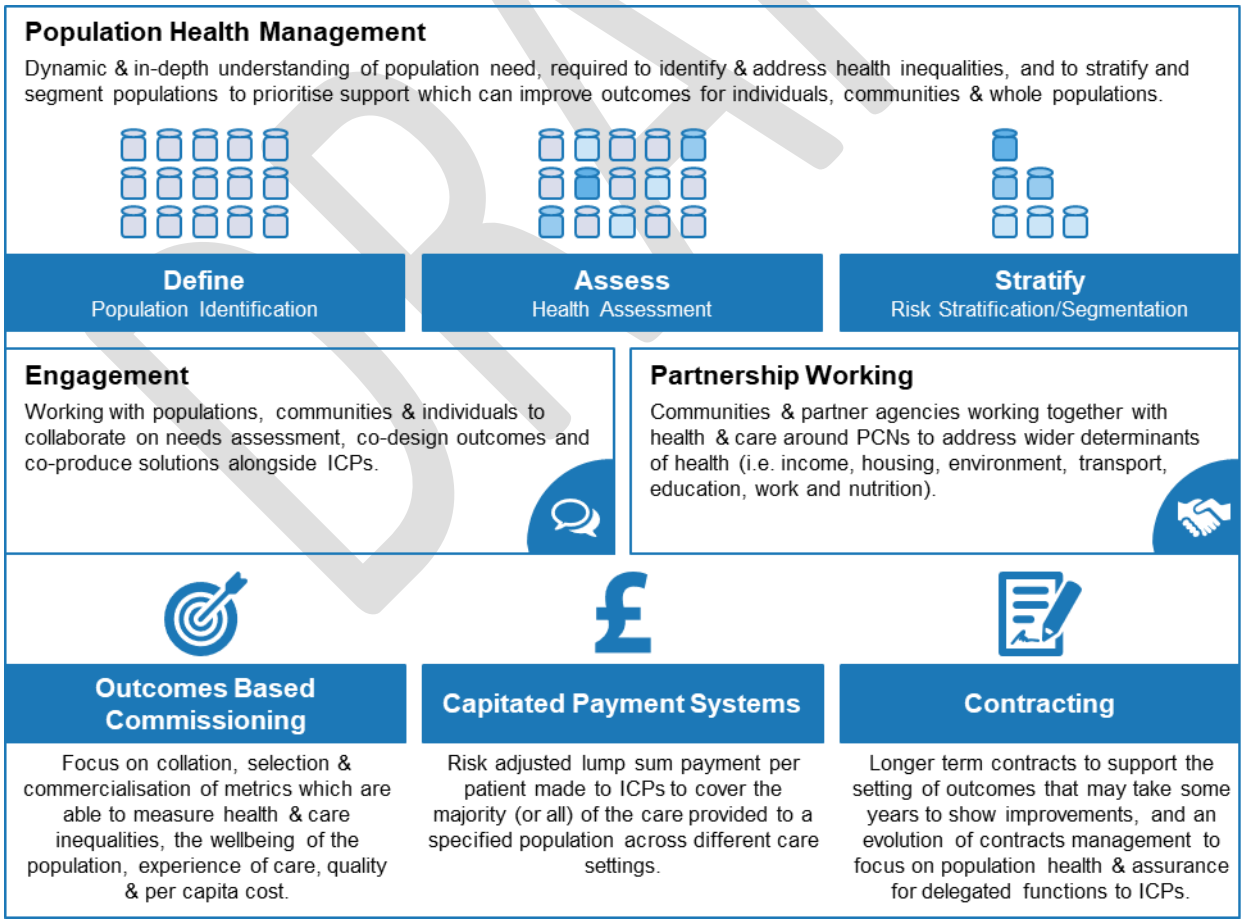


Figure 14: Our emerging approach to population health management

Moving to a PHM approach is dependent on the change capabilities within local systems.

Places and neighbourhoods will need to be supported to roll-out PHM tools to identify groups at risk of adverse health outcomes and inequalities, and to plan services accordingly.

The Sussex Health and Care Partnership will develop two frameworks in 2019/20 to assist partners in understanding the steps needed to implement an effective PHM approach:

1. **Population Health Maturity Assessment Framework**. This will address overall system maturity and enabling factors such as system leadership and governance, culture and engagement, data and analytics, technology, and financial and organisational models

2. **Population Health IT and Data Analytics Framework**. Technology underpins success for PHM systems, and it is important that the correct IT and digital infrastructure is in place to support PHM roll-out.

4.1.4. Supporting collaborative delivery of the LTP commitments

Our new strategic model is designed to facilitate ongoing service improvement and transformation. As a starting point, we will work to deliver the substantial number of commitments set out in the Long Term Plan alongside our local priorities, as described in section 7.

Many of these transformation priorities will be planned and delivered at the place-based level. To support and supplement this planning, we are collaborating with established clinical networks (e.g. the Local Maternity System) and developing system-level partnerships that target specific improvement areas. Across our footprint, we will make use of partnerships and clinical networks to ensure that clinical leadership is the cornerstone of system development. Over time different networks will be developed to address key system issues and the function of these will be agreed by the Partnership Executive.

One such partnership is our Acute Collaborative Network, which is described in more detail below.

Our Acute Collaborative Network

The four acute providers across Sussex have established a Sussex Acute Collaborative Network to:

- Strengthen the strategic partnership between organisations
- Ensure ongoing collaborative working in the development and delivery of sustainable models of care
- Oversee, coordinate and help a programme of work that requires input from across the system and aligns with the strategic priorities of the Partnership.

Initial priority areas for improvement, including Head and Neck (including OMFS and ENT), Dermatology, and Adult Burns, have been agreed by the Sussex Health and Care Partnership Executive. In addition, the Acute Collaborative Network is undertaking a prioritisation exercise to identify and agree further workstreams where collaboration between acute providers within Sussex could deliver improvements in services for the Sussex population, support providers' individual clinical and financial sustainability, and that of the Partnership.

Priority workstreams will be those that require providers to collaborate and determine an optimal way to transform provision and deliver benefit to the Sussex-wide population. The network will be responsible for developing proposals for service transformation and reconfiguration, bringing together providers and facilitating engagement with commissioners, system partners and the public to refine and deliver optimal services.

3Ts Development

The major development of the Royal Sussex County Hospital site (the 3Ts development) provides a significant and exciting opportunity to develop services in Sussex for the benefit of patients locally. As set out in the 3Ts Business Case, there are opportunities to develop Neurology and Neurosurgery services so that Sussex patients no longer need to travel to London for their care. There are further similar opportunities to strengthen tertiary care , such as Cardiac Surgery, specialist Stroke services and the co-location of Burns care on the Major Trauma Centre site. The Sussex Acute Collaborative Network will explore and promote these and other areas to maximise the benefit of the 3Ts development.

4.2. Establishing place-based Integrated Care Partnerships

The Sussex Health and Care Partnership will consist of three places, contiguous with local authority boundaries in Brighton & Hove, East Sussex and West Sussex. Each place is responsible for population health management and commissioning, and for delivering joined-up health and social care for its local population, which will be provided at or as close to home as possible.

To achieve this, each place will establish new community and prevention-based models of care, aligning providers to deliver: seamless end-to-end patient pathways in a timely and efficient manner; integrated population health and care commissioning; and partnership governance arrangements, including the development of an Integrated Care Partnership to mirror the population health and care commissioning footprint.

Key service transformation priorities for places include:

1. Supporting development of PCNs
2. Transforming out of hospital care and fully integrated community-based care
3. Reducing pressure on emergency hospital services
4. Reducing waits for planned care
5. Giving people more control over their own health and more personalised care
6. Supporting digital transformation of primary care and outpatients
7. Ensuring a strong start in life for children and young people
8. Improving prevention and care for respiratory conditions
9. Shifting care settings to the place-level where this is the best option.

Detail on each of the place-based delivery plans can be found in Appendices B – D, and common principles are outlined in section 7 below.

To enable their development and maturation, the places will need to develop a number of elements which are detailed in the remainder of this section.

4.2.1. Integrated Care Partnership agreements

Each place will be responsible for developing an Integrated Care Partnership. These will function as partnerships of sovereign providers that:

- Deliver end-to-end healthcare
- Coordinate care planning, management and integration to address the wider determinants of health
- Model and manage care delivery including developing operational plans, optimising whole system pathways, and allocating resources against delivery of contracted outcomes
- Manage and evaluate quality and performance, and ensure delivery of constitutional standards
- Provide services that are best delivered on an ICP footprint, such as medicines optimisation, clinical training and education, and emergency planning, supported by effective use of technology.

This Partnership will include local authorities, acute hospital trusts, commissioners, community services, mental health providers and other providers within a neighbourhood, as well as representation from the voluntary sector.

It is proposed that ICPs are developed and delivered in three phases across 2019/20 and 2020/21. These phases will be as follows:

- **Phase 1 – Establishing the programme**. Partnership principles, definition, scope, partnership agreement to support development of the ICP.
- **Phase 2 – Programme planning**. Detailed programme plan, leadership and governance arrangements, financial and risk management.
- **Phase 3 – Partnership development**. Collaborative service design, quality and safeguarding frameworks, primary care development, contracting framework, ICP delivery vehicle, workforce development.

4.2.2. Place / ICP infrastructure and governance

Each place will require a shared leadership agreement regarding the establishment of the necessary governance, assurance, contracting, performance and financial management to support partnership working.

Delivery and planning will be coordinated and overseen by an ICP Board and a named SRO, who will report on progress to, and be held to account by, the Partnership governance. The Partnership will retain responsibility for regional strategy and assisting ICPs with developing capacity at a place-based level. The ICS will also serve as an intermediary between national and regional NHS entities, providing a mechanism to align regulators to support integration at the local level.

Each place is currently developing their own governance structure, with ultimate oversight sitting with a place-based Board. Each place-based plan sets out what specifically statutory partners are going to deliver to improve outcomes for individuals and the wider population, and will provide the guiding framework for accountability.

4.2.3. Outcomes-based commissioning and population health management

Commissioning and prioritisation decisions will be based upon the Partnership's population health management model, seeking to address the themes identified in the Population Health Check as well as the needs of local communities.

Each place will implement a clear outcomes-based commissioning framework in partnership with CCGs and local authorities. These frameworks will be developed in collaboration with the Partnership and based on the outcomes identified as important by the local populations.

To support this, we will change the way we assure financial performance and align this to a population health management approach.

For example, a significant proportion of contracts are already aligned incentive contracts for 2019/20 and we are exploring risk-sharing models to drive changes for patient cohorts. This could include a risk-adjusted capitated payments approach for long term contracts with ICPs to cover the majority (or all) of the care and support provided to our population across different care settings.

The 'place' levels provide sufficient scale to operate one or several risk bearing contracts, since risk can be spread across providers and improve cost forecasting with a larger population base. Our payment models will need to incentivise the system to deliver our new models of care, and the system is committed to identifying innovative and risk-sharing options to engage both providers and commissioners.

4.2.4. Local authority partnerships

Each place is working to strengthen engagement with local authority partners for integration of care and population health and care commissioning. This will include regular scheduled meetings with senior local authority leads to continue to improve working relations, and partnership with the local authority delivery functions.

4.2.5. Communications and engagement

We will develop a framework to ensure ongoing engagement with communities, staff and other stakeholders with regard to the impact of integration on care and to support a co-design approach to the development of services. Our partnerships will be focused on inclusivity and equity, with an unequivocal focus on addressing the wider determinants of health.

4.2.6. Current state

Current place-based structures have established good collaborative working between system partners, and these relationships will form the foundation for the transition to ICPs.

Our achievements so far include:

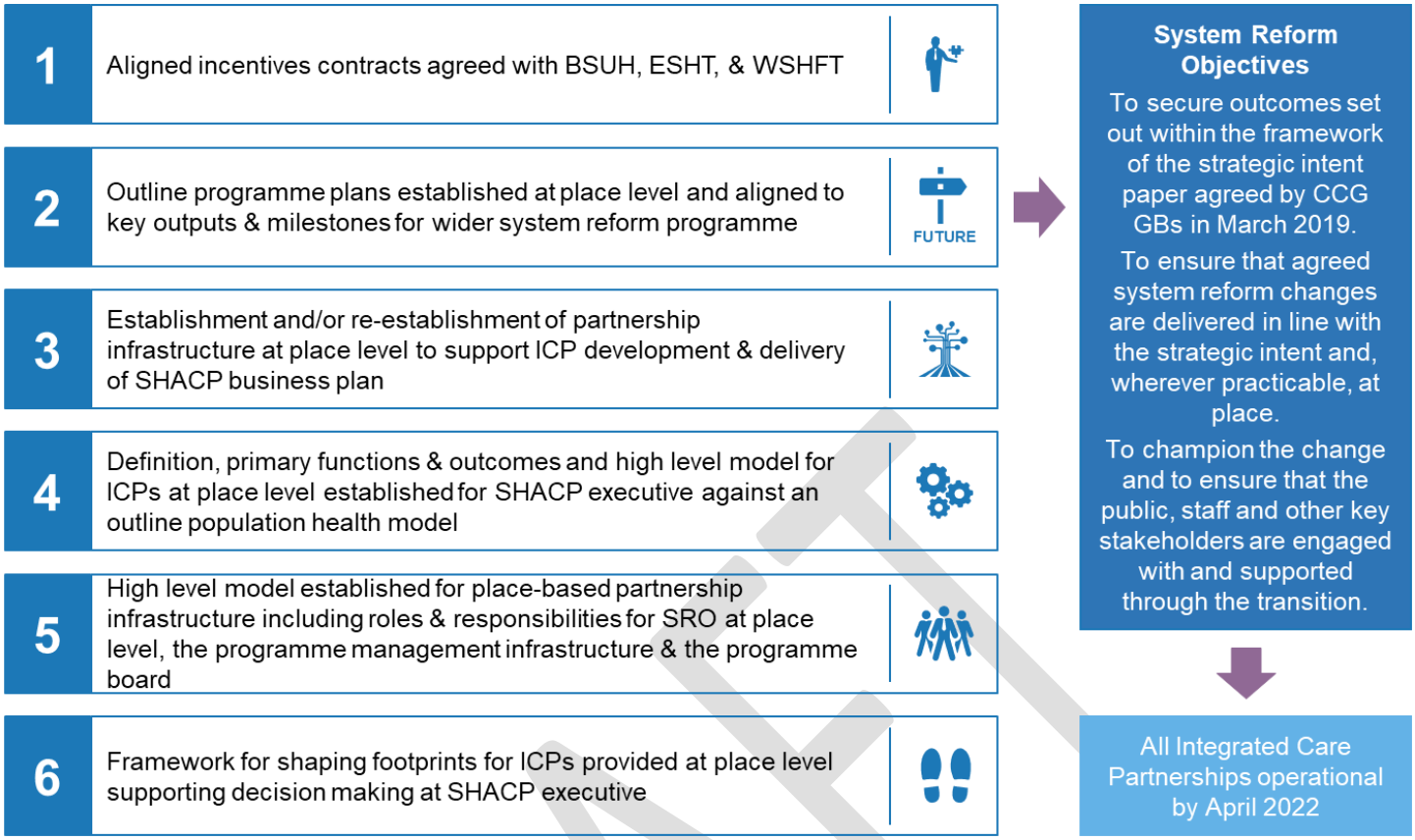


Figure 15: ICP transition achievements

4.2.7. Next steps

In order to facilitate this, the places are aiming and being supported to:

- Engage and co-produce with patients and the public, detailed care delivery models to address inequities of access and ensure new services meet the local needs
- Work in partnership with local neighbourhoods and PCNs, supporting PCNs to bring together GPs to work together with local community services, mental health, social care, pharmacy and voluntary sector teams, to provide integrated health and care for patients and the population, at the neighbourhood level
- Manage and evaluate ongoing quality and performance, including regulatory compliance and delivery of constitutional standards.

4.3. Neighbourhood-based Primary Care Networks

Primary care plays a pivotal role in the NHS, being the entry point for the prevention and treatment of illness. However, it currently faces unprecedented pressure, due to increasing patient numbers, patient needs and workforce challenges. Traditionally, primary care was defined as general practice, community pharmacy, dental and optometry services. Nowadays, though, the scope and delivery of primary care is much wider, incorporating appropriate self-care interventions, mental health support, community health care teams and multidisciplinary care.

A great deal of progress has been made by the Sussex CCGs in supporting general practice to increase the resilience and sustainability of vulnerable practices, and in implementing the

ten ‘High Impact’ changes set out in the General Practice Forward View to improve efficiency and resilience, and work continues across these areas. The Long Term Plan now provides the mandate to build on this foundation and our plans to date, in the delivery of integrated primary and community care.

There are strong examples of integrated care already in place across our CCGs and, over the last 12 months, work has begun to identify best practice from our urgent care, planned care, care home and frailty pathways and locally commissioned services. This will help us establish a baseline, build on the learning, and develop plans that support the continuation of work at scale to progress and develop care close to home, supported by the integration of general practice, voluntary, community and social care.

More recently, work has focused on the establishment and development of Primary Care Networks across Sussex, in preparation for PCNs to work in partnership with and be supported by all key health and care partners across the system as an ICP.

Under our new operating model, a greater proportion of services will be delivered in neighbourhoods close to the individual’s’ home, shifting activity from acute to community and primary care services. This shift will be facilitated by the development of Integrated Care Partnerships (ICPs), bringing together teams from general practice, community services, social care, pharmacy and the voluntary sector to design and deliver integrated pathways of care and local services in neighbourhood-based Primary Care Networks.

To support this transition, CCGs are developing a programme of work to support PCNs to develop, mature and therefore be prepared and able to contribute to and work with community care providers in an ICP.

Over the next five years, we will work with the PCNs across our footprint to deliver these new models, working within three core areas:

1. **Service transformation and improvement within primary care** to support practices to deliver a consistent, accessible and high quality service
2. **Formation and development of effective PCNs**, setting up the core structures and processes needed to enable our PCNs to deliver as mature organisations
3. **Delivery of the new network specifications** and the commitments of the LTP.

4.3.1. Current state and context

Within the Sussex footprint, there are 178 GP practices, of which seven are Care Quality Commission (CQC) rated ‘Outstanding’, 161 ‘Good’, six ‘Requires Improvement’ and four ‘Inadequate’. The practices vary in size, the smallest registered list being c 1,400 people and the largest c 25,000, and are organised into 38 Primary Care Networks, covering 100% of our population. All our practices participate in The Quality and Outcomes Framework (QOF), with good achievement of between 93.5% - 100% in 2016/17.

Over the last five years there have been a number of practice closures and mergers as a response to retirement of partners and salaried GPs, and the introduction of general practice at scale. The Sussex STP is facing continuing workforce challenges across primary and community services caused by well-documented workforce shortages across many professions. The GP workforce in Sussex is similarly challenged, with many practices adopting a broader multidisciplinary approach to care delivery to manage patient demand

and increase capacity.

4.3.2. Service transformation and improvement within primary care

High quality, resilient and accessible general practice is essential to the delivery of responsive and integrated care. A key focus of the CCGs work programme is to continue to support general practice in tackling their core existing challenges and pressures, to create sustainable primary care.

Under the GP Five Year Forward View, funding for four programme areas has been allocated to support transformation within general practice, with a phased delivery plan underway. There are a number of other workstreams, enablers and plans also proceeding to support primary care, PCN and ICP sustainability and development, some of which have been described in other chapters pertaining to ICPs, integrated urgent care, digital and workforce plans.

Detailed operational plans are in place to support delivery, and a high level summary of some of the ongoing work in each area is shown in the figure below:

Work Programmes	Outline plans
GP resilience	• Standardise processes, policies and investment approach, targeting the most challenged practices to improve resilience and supporting vulnerable practices at risk of closure • Standardise our Vulnerability matrix / Quality Assessment tools • Continue to support vulnerable practices and re-purpose the primary care commissioning team to become more externally focused, to better support general practice and PCN • Continue to provide dedicated CCG support to individual practices and PCNs, working closely with LMC and lead clinicians • Adopt a single approach to practice performance reviews and membership engagement through GP and Practice Manager forums
GP retention	• Review the GP and wider primary care team recruitment and retention initiatives developed by each of the Training Hubs in Sussex and adopt the successful programmes • Continue to develop portfolio career opportunities for GPs targeting ST3s, locum GPs and GPs leaving the profession • Develop GPwSI posts in mental health • Further develop GP Fellowships which include more flexible arrangements tailored to the needs of the individual GP • Support PCNs in the recruitment of the Additional Roles and Reimbursement Scheme (ARRS) with the development of social prescribing, pharmacists, and first contact practitioner, paramedic practitioner and physician associates roles
Reception and clerical	• CCG PCN leads continue to support practices and PCNs to share best practice, identify, and source training opportunities

Work Programmes	Outline plans
training	for general practices' reception and administration teams • Assist in the availability of workflow optimisation programmes, medical terminology training and enhanced reception and clerical staff training
Improved access	• Support the delivery of extended hours as part of the PCN Directed Enhanced Service (DES) requirement • Ensure delivery of the Improved Access (I/A) national specification requirements • Work with Urgent Care Centers (UCC) and Urgent Treatment Centres (UTCs) to connect I/A service with UCC • Work with PCNs and providers to prepare for and deliver the new national Extended Access specification when released to 100% of the PCN population
Digital Programme	• Board and Primary Care Digital group in place to provide governance and consistency across the STP • Project methodology compiled across the STP footprint to enable consistent prioritisation to take place for all digital developments • On line consultation: • Continue with the roll-out of online consultation in Eastbourne, Hailsham and Seaford CCG (EHS) and Hastings and Rother CCG (H&R) to all practices • Audit and evaluate the effectiveness of the programme • Deliver the procurement plan to implement online consultation in the remaining five Sussex CCGs, starting in October 2019 • Digital First – funding has been received from NHS England to support the development of four areas: ○ Promote and enhance the digital skills of our local population and GP practice workforce. ○ Develop an intuitive GP online resource portal, providing referral and pathway information (for health professionals) and supporting the development of PCNs. ○ Support the use of the NHS App as a digital health and care front door for East Sussex, so people have one place to access information, advice and support. Further information on our targets for this is set out in the Strategic Planning tool. ○ Enhance clinical engagement and leadership in digital programmes. ○ Support PCNs to with the intraoperability of their clinical systems.
Estates / Estates and Technology Transformation Fund	• Prioritisation database compiled across the STP footprint to enable consistent ranking to take place when considering service needs and potential new developments

DRAFT

Work Programmes	Outline plans
(ETTF)	• Primary Care Premises and Estates group established to provide governance across the STP, with representation from all CCGs, NHSE/NHS Improvement, NHS Property Services, mental health, community trusts and other system partners • A number of new builds and refurbishment developments underway and at differing stages of planning and build • All new developments include community services and use new technology to enable efficient ways of working, e.g. video consultant appointments and Skype consultation
Locally commissioned services	• Work programme underway to review all locally commissioned services (LCS) across Sussex, to establish a baseline of LCS and standardise approach where appropriate • Approach and principles developed with LMC

PCN 7 national specifications	• CCG PCN leads to work with each PCN to ensure they are prepared to deliver the national service specifications:
	• **2020/21**
	  ○ Structured Medicines Reviews and Optimisation
	  ○ Enhanced Health in Care Homes
	• **2020/21 onwards**
	  ○ Anticipatory Care requirements
	  ○ Personalised Care
	  ○ Supporting Early Cancer Diagnosis
	• **2021/22 onwards**
	  ○ CVD Prevention and Diagnosis
	  ○ Tackling Neighbourhood Inequalities

LTP requirements relevant to primary care & ICPs	• Contribute to the co-design of the ICP plan and implement the LTP requirements linked to primary and community care

4.3.3. Formation and development of PCNs

Across the Sussex footprint, the 38 PCNs are in various stages of maturity and have different levels of ambition and aspiration. All PCNs have been given access to the following:

- Data packs to assess the health needs of their populations, including understanding where health needs and inequalities exist for their patients
- Additional CCG staff resources and funds to assist in their formation and development
- Information about resilience and how practices within the networks can be supported to become and remain resilient.

During November 2019, each PCN will self-assess against the NHSE PCN Maturity Matrix. The findings will be built into a PCN and Clinical Director development programme which will

be informed by the national development prospectus and designed jointly by CCGs, PCN CDs, NHSE and the LMC. This will be nationally funded and will include:

- Access to support to develop the Clinical Director role
- Clarity about the support the CCGs will offer to PCNs in terms of resource
- Access to legal advice and support to allow development of services to be underpinned by robust governance
- Support for the development of vanguard PCNs to test and take forward functional delivery, sharing best practice as it is developed.

In addition, and to further support PCNs to move at pace, ahead of the national minimum requirements, an accelerator programme has been offered to PCNs to drive progress, support the desired integration of services, and reduce clinical variation across the Sussex STP foot print. The aims of the programme are shown in the figure below.

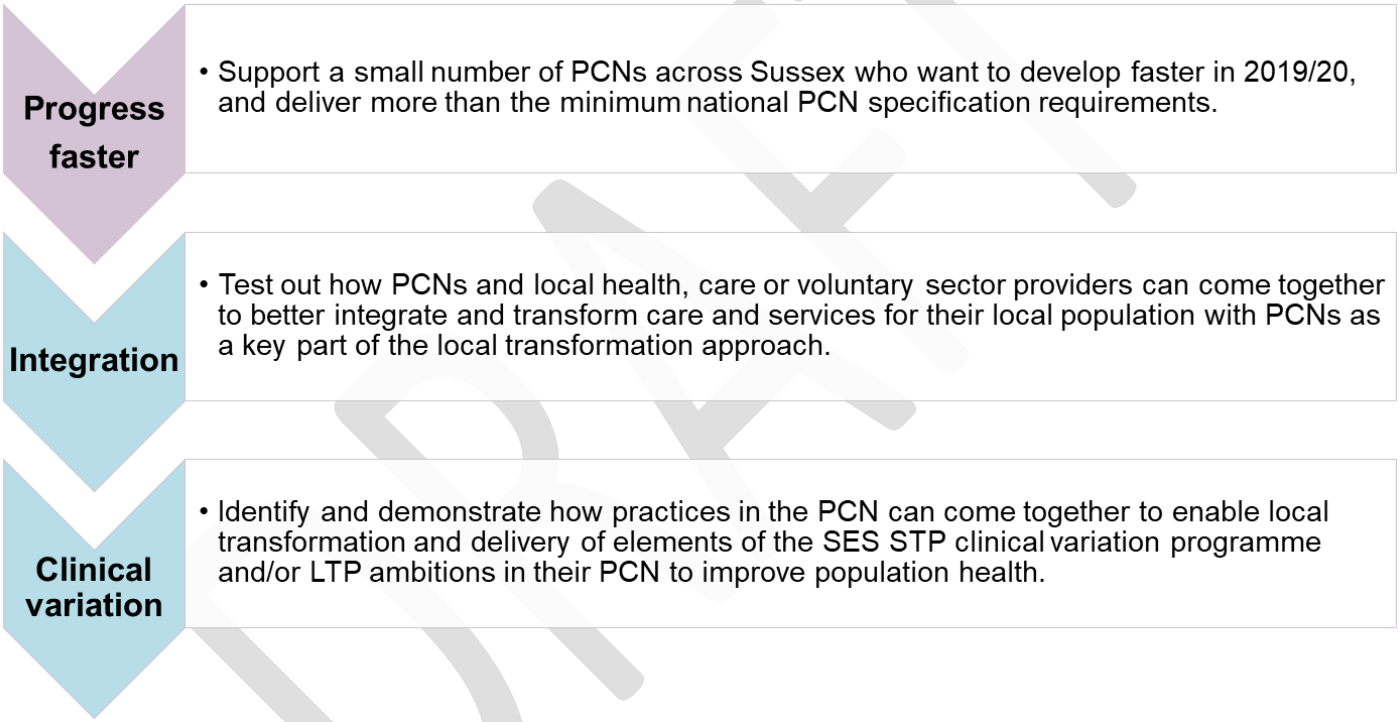


Figure 16: PCN accelerator programme aims

As part of the accelerator programme, PCNs will be asked to deliver against four core areas of focus and will have additional resource made available to support this. The areas of focus for PCNs are:

- Developing and accelerating the PCN to progress at pace, mature and deliver its ambition
- Delivering/testing out in the PCN the Sussex STP Clinical Variation Programme ambitions and requirements (Musculoskeletal falls, Diabetes and Cardiovascular disease)
- Delivering the requirements of the LTP (including anticipatory care, personalised care and early diagnosis for cancer)
- Integrating joint working of the PCN with other providers to better support integrated care and MDTs, improve the PCN population's health, and better integrate urgent or

planned care pathways to improve system flow, avoid admission and improve value for money.

4.3.4. Delivery of new service specifications

The Primary Care team are supporting PCNs to develop delivery plans detailing their ambitions and aspirations to improve their PCN population's health, and to deliver the DES, GPFV and LTP requirements.

In line with the timescales set out in the GP contract reform, PCNs will start to deliver core services from Year 2, including Enhanced Care in Care Homes, anticipatory care and medicine optimisation for target groups. Our ICPs will work in conjunction with PCNs to develop detailed operational delivery plans to each of these commitments, to meet the national deadlines and targets. Each place has been developing pilots to support their development of their PCNs.

4.3.5. Programme management

A roadmap of PCN development is shown in the figure below.

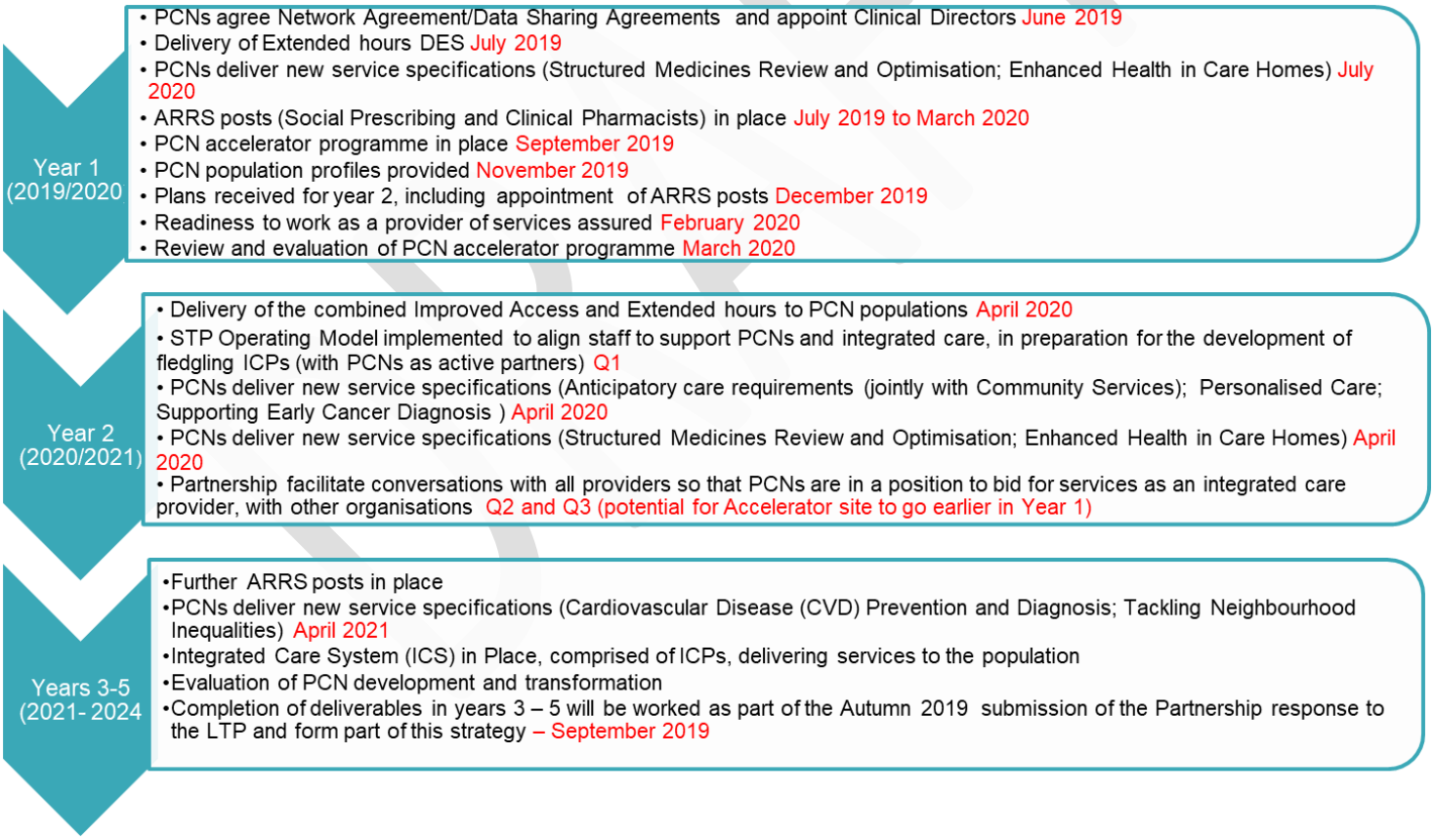


Figure 17: PCN development roadmap

The local governance arrangements for this programme, and how they align to existing CCG and Sussex governance, are set out in the diagram below. A Primary Programme Board, chaired by a CCG Lay Member for Public and Patient Involvement, is established across Sussex to provide coordinated strategic leadership and oversight of the GPFV, PCNs and new models of care and integration.

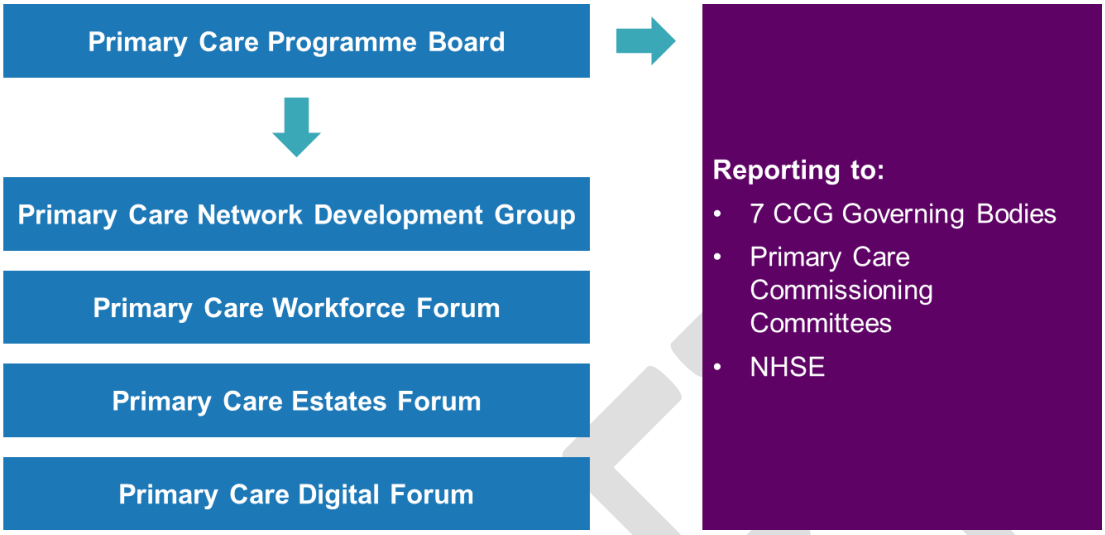


Figure 18: PCN governance

4.4. The role of Specialised Commissioning

Specialised Commissioning will build on the opportunities provided by our transition to an ICS by ensuring specialised services are planned and delivered as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.

As a future ICS, we will work with Specialised Commissioning to plan specialised services alongside locally commissioned services, providing the opportunity to transform and improve clinical engagement across integrated whole system pathways and positively influence health outcomes. The end-to-end integration of pathways will deliver benefits to patient outcomes and experience, reduce unwarranted variation and improve value for money. Investment in prevention and management during earlier stages in the patients' pathway should deliver a reduction in demand for some specialised services, and an integrated approach will enable services to be more responsive to the needs of the local population.

Specialised Commissioning will continue to identify opportunities for collaboration by aligning work programmes, using existing forums as a vehicle for considering these, with reference to service reviews and procurements. Where required and appropriate, services will be redesigned at a system or broader level to maximise clinical efficiency and financial resources, and to provide opportunities to align improvement programmes through joint planning and contracting.

To support the integration of specialised services into the ICS, the Partnership and Specialised Commissioning will work together to develop a roadmap to achieve devolution of commissioning of appropriate services. We will implement a framework to enable us to make decisions collectively on specific local arrangements, whilst ensuring that any proposed model of integration remains within the existing legal framework. This will be set in the

context of the wider system architecture for those services which span more than one ICS population.

The framework requires further development but is likely to be made up of the following:

- National parameters within which ICSs can take on more responsibility. This will clarify the extent of the responsibility that ICSs can have for specialised services, and the ongoing role of our corporate and regional commissioning teams.
- Principles to support decisions on which services can be in scope.
- Readiness criteria that ICSs should meet before taking on more responsibility for specialised services.
- Governance arrangements for signing off proposals.

Specialised Commissioning has agreed to make team members available as a resource for ICS teams. We will work in collaboration to ensure quality and compliance with commissioning standards, and look to repatriate services currently being provided outside the system closer to home where this is both in patients' best interests and supports sustainability of system providers, for example, ensuring funding transfers are secured.

5. Investing to deliver change: our financial framework

5.1. Our route towards financial sustainability

Note: this section reflects the system position as at Friday 18th October. Under the guidance of Finance Group, the system is still working on its financial planning. The current placeholders highlighted in yellow in this narrative will be finalised following a meeting of the Finance Group on Monday 28th October, in time for the 1st November LTP regional submission.

The system has recently achieved a significant improvement in its overall financial position against a trend of national decline. The aggregated outturn for NHS providers and commissioners across the system, including sustainability funding, improved from £(229.2)m in 2017/18 to £(49.5)m in 2018/19.

Nevertheless, financial challenges remain. The current forecast outturn for 2019/20 is a deficit of £(74.4)m post-sustainability funding, or £(169.8)m pre-sustainability finding. Our system-wide "Do Nothing" modelled scenario projects a pre-sustainability funding deficit of £(284.5) by 2023-24.

Summary of plan relative to NHSE/I improvement trajectories

The system has been set a trajectory of improvement to £(103)m (excluding NHSE&I funding) by 2023/24. We do not have a plan to acheive that as a system. The overall trajectory is an aggregation of targets for individual organisations. The trajectories are based on the control totals set for 2019/20. Queen Victoria Hospitals (QVH) and Crawley and Horsham and Mid Sussex CCGs do not have plans to meet those 2019/20 control totals. There is, therefore, a planned gap from the outset which cannot be bridged by a system already delivering savings which are significantly higher than national assumptions.

QVH is not in a position to sign up to its trajectory because of a £7m gap between 2019/20

plan and control total, together with additional pressures likely to impact in-year. Over the past couple of years, it has become increasingly clear that QVH, as the second smallest trust in the country, has experienced challenges in maintaining clinical and financial sustainability. In 2018/19 the trust reported a £4m deficit. In May 2019, in agreement with the regulator and commissioners, a Programme Board was established to consider the future of QVH. Since then, a case for change has been agreed and work has begun on an options appraisal/critical success factors; this process will take time and there are limited short term opportunities to deliver savings. The publication of the Long Term Plan supports the timing of the consideration as to where QVH sits in the redesign of patient care.

Crawley and Horsham & Mid-Sussex CCGs together face a £7.6m gap between 19/20 plans and control totals alongside likely additional in-year pressures of £22m. This creates a gap from the 20/21 financial target in the region of £30m. There is no short term recovery plan for these CCGs and they are therefore unable to develop a financial plan which would meet the trajectories.

Placeholder for cross-system narrative in collaboration with Surrey Heartlands to explain collective actions guiding North ICP recovery approach.

Placeholder for potential risk associated with WSHT/Coastal West Sussex CCG

Compliance with funding guarantees

The system is fully compliant with the requirements of both the Mental Health Investment Standard and the Primary Medical and Community Services funding guarantees.

Approach to efficiencies

The system has planned to meet the national requirements to include 1.1% savings for providers, another 0.5% for those in deficit. In order to reduce the size of the system financial deficit and improve the financial sustainability of the system, a number of organisations have planned for significantly greater savings. Local places have worked in partnership to identify opportunities to improve services whilst reducing costs, and will continue to do so.

Placeholder for table showing system savings

Working at a system level has enabled progress to be made in system-wide programmes including unwarranted clinical variation, urgent & emergency care and clinically effective commissioning. Benchmarking information indicates that there may be significant opportunities in these areas. These system-wide efficiency plans will continue to be be developed through the operational planning process so that they can be throroughly tested and incorporated in organisations' plans in a more granular way. Alongside this, the system will be examining the return on investment of its increased spending on primary, community and mental health services – to ensure value for money and corresponding efficiencies elsewhere in the system.

The system makes full use of comparative information such as Model Hospital, Rightcare and GiRFT to proactively look for areas for improvement.

Specialised and Direct Commissioning

The system does not consider the provider envelopes set by the region to be based on

robust QIPP assumptions**.** We have identified the variance between locally modelled expenditure projections and the region's provider envelopes. This will be the starting point for working with the region on agreeing what reasonable efficiency assumptions would be. This dialogue will be ongoing beyond the window of the final submission.

Cash management

We will continue to actively manage cash whilst the system remains in deficit. Access to working capital will be agreed with NHSE/I on a timely basis to ensure that this does not impact on the delivery of services for patients.

The rest of this section sets out the enablers which will support the system on our route to financial sustainability.

5.2. Our system's financial framework

Sussex is on the ICS Accelerator Programme, and building a robust financial framework for the ICS and the ICPs will be an integral part of this work. There are some clear characteristics that are important in the development of effective ICSs/ICPs which include:

- A well constructed operating plan that aligns activity, finance and workforce
- A shared approach to investment
- System level financial governance arrangements
- Tools and systems that monitor progress
- Agreement on efficiencies to secure in-year and longer-term financial sustainability
- Aligned incentives and payment mechanisms.

To this end, the system's Finance Group is developing a financial framework underpinning the system's financial strategy. The intention of the financial framework is to guide system-wide planning towards financial sustainability, and to build collective responsibility for achieving this.

The framework first articulates system-wide shared planning principles – these incorporate the LTP's five financial sustainability tests. The principles also reinforce how system-wide financial planning should be aligned with agreed assumptions used in our local modelling system. These assumptions cover:

- Activity growth rates – based on locally agreed figures
- Cost inflation – based on nationally-aligned assumptions
- Tariff inflation and efficiency – based on nationally published figures.

Following this financial planning context, the framework sets out target and affordable spending by sector – including both health and social care expenditure, and incorporating funding guarantees for primary and community health. The projected *Do Nothing* risk by sector is then presented, which will be followed by a bridge of system-wide *Do Something* efficiencies to mitigate this deficit, together with the groups responsible for delivering these efficiencies. The purpose of setting out a bridge in this way is to drive delivery of and accountability for the efficiencies, thereby providing greater assurance on the route to system-wide financial sustainability outlined above. The resulting forecast Do Something spending will then be tested back against the target/affordable spending by sector to ensure overall alignment.

5.3. Developing system-wide financial assurance

The system has already achieved significant progress on developing financial assurance. Our Finance Group is regarded as an exemplar system-wide group in Sussex, developed on the principles of strong partnership working and transparent information sharing. The Group has a robust process for monitoring the system-wide financial outturn and can take collaborative action on contract alignment issues.

We have a robust modelling system in place which supports strategic planning by providing 5-year activity, finance and workforce forecasts for health organisations system-wide. This enables a good understanding of system financial drivers. Modelling assumptions have been developed collaboratively and are reviewed regularly. We are currently planning the next development phase of the modelling system, to support a direction of travel where modelled financial outputs more closely reflect and inform the reality of contracting agreements and internal funding flows.

Where contracting agreements or in-year trajectories diverge from those in the model, a clear audit trail is required to transparently account for this variance and system recovery actions put in place where required. This will provide the Finance Group with a more detailed level of oversight and enable it to take on a greater assurance role in collectively managing system resources.

As the Finance Group increasingly develops from a well-functioning group that oversees collaborative working and transparent information-sharing to one which takes on responsibility for system-wide financial assurance, we are learning from the working arrangements of Finance Groups in more mature ICSs.

5.4. Developing payment reform options

The system has already made good progress on this agenda, with most contracting arrangements already set up on an aligned incentive basis. We are currently examining options with the support of the national payment reform team – through a set of exploratory workshops with the Finance Group – for moving towards more sophisticated blended payment models. This will be coordinated in conjunction with the Accelerator Programme. Our system is committed to identifying and deploying innovative risk-sharing options through a process that collaboratively engages both providers and commissioners.

DRAFT

6. Putting prevention at the heart of our plan

6.1. Current state and challenges

Prevention is one of the central building blocks of our Sussex health and care strategic model and is, therefore, the responsibility of our whole system. A focus on prevention and on reducing health inequalities is central to the planning of all workstreams, and to our work around system reform and development towards becoming a maturing ICS. Our ambitions detailed in this strategy are not only the responsibility of the Prevention Board, but are dependent upon the work of the wider health service, councils, police, education, the voluntary sector, businesses, communities and individuals.

The Sussex Health and Care Partnership Prevention Board will work in collaboration with a number of Partnership-wide programmes in the implementation of primary prevention commitments, including those relating to cancer, and to long term conditions such as diabetes, CVD and mental health. Clinical programmes will lead strategic planning, delivery and monitoring of secondary prevention activities. However, pathways for secondary prevention and recovery pathways will be joined up with place-based delivery of local wellbeing services by Councils and other partners, to ensure a cohesive service and consistent outcomes for our population.

NHSE is responsible for commissioning public health services including NHS screening services, immunisation services, the Diabetes Prevention Programme, and child health information services. They are supported by, and work in close collaboration with, Public Health England (PHE), which delivers outcomes through regional Public Health Commissioning teams with their embedded Screening and Immunisation teams.

6.1.1. The wider determinants of health

We are committed to building a culture in which individuals, organisations and communities work together to identify and pool their capacity, skills, knowledge, assets and resources to improve health and wellbeing outcomes for all our residents.

DRAFT

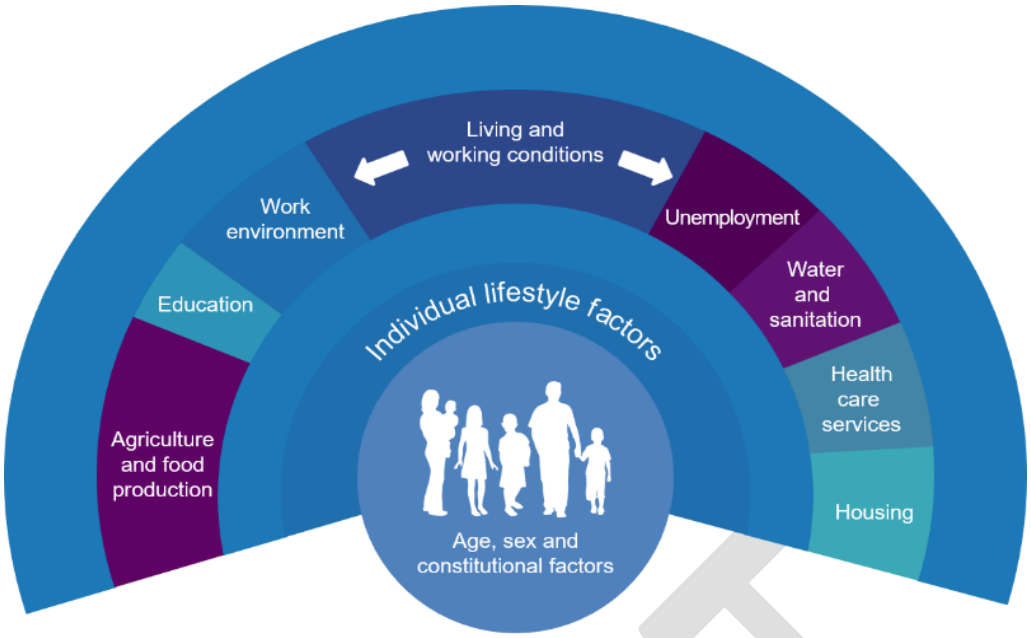


Figure 19: Individual lifestyle factors affecting health

This approach requires a shift from a demand management approach to a whole system approach to prevention which addresses "the causes of the causes" as identified in the Dahlgren and Whitehead model (1991). The "causes of the causes" cover a wide range of health determinants, from social determinants to those of the built environment, and these require concerted, sustained partnership working.

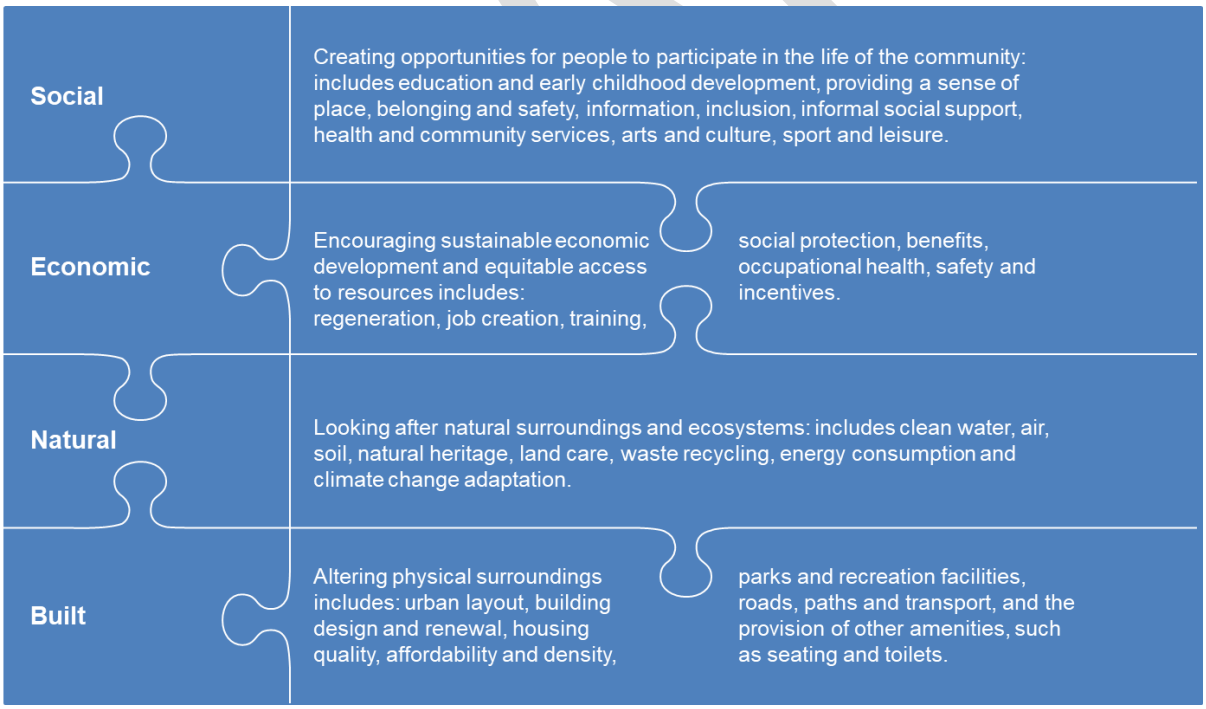


Figure 20: Health in All Our Policies (Local Government Association 2016)

6.1.2. Our population and inequalities

Our Joint Strategic Needs Assessments (JSNAs) highlight priorities for Sussex including:

- Good mental health and wellbeing which underpins health outcomes
- Poor physical health which is linked to risk behaviours and influenced by the wider determinants of health
- Health inequalities resulting from social and income inequality
- Healthy futures which are built on stable employment and appropriate housing

These priorities for our population must be considered within the important context of the significant variations in socioeconomic status, health outcomes, environment and economic prosperity across Sussex. There remain considerable, and unacceptable, differences in service access, take-up, outcomes and life expectancy between areas across Sussex and within CCGs, which the Partnership is committed to addressing. One of the central tenets of our strategy is delivering high quality health and wellbeing for our most disadvantaged members of society through a Population Health Management Approach which may include targeting groups such as BAME communities or those with Learning Disabilities. We will ensure that we continue to monitor this variation for a range of measures including: cancer screening uptake, immunisation uptake, rates of smoking and alcohol misuse, and obesity levels, to assess the effectiveness of targeted and pilot interventions in areas of greatest need.

Life expectancy varies considerably across the area:[5]

- In Hastings & Rother, male disability-free life expectancy is over five years lower than in Horsham & Mid Sussex and High Weald, Lewes Havens (2010-2012)
- Hastings & Rother also has the lowest female disability-free life expectancy at 64.1 years, compared with Horsham & Mid Sussex at 69.4 years (2010-2012)

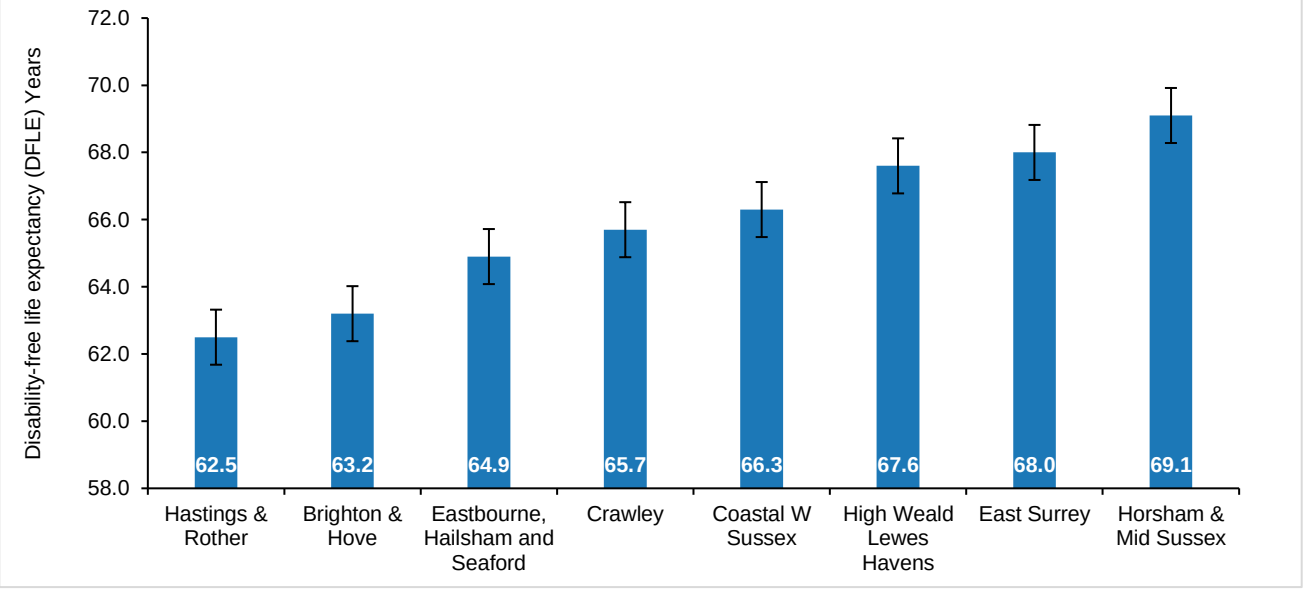


Figure 21: Disability-free Life Expectancy Men (2010-2012)

[5] Disability-free life expectancy 2010-2012, ONS

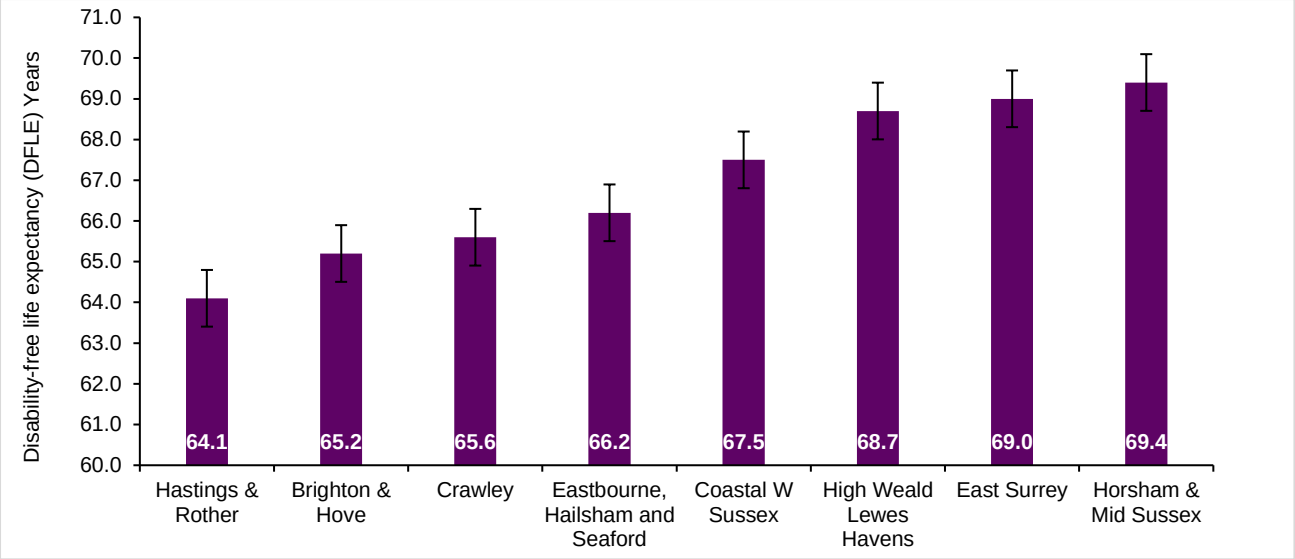


Figure 22: Disability-free Life Expectancy Women (2010-2012)

Deprivation is a significant driver of health inequalities and is notable along the coastal strip, particularly in Hastings which is the most deprived local authority in the South East. As a large Partnership, this understanding of our significant variation means that our three places and emerging Integrated Care Partnerships (ICPs) can specifically address inequalities by targeting interventions at areas of most need as indicated by our data on smoking, alcohol, obesity, deprivation and life expectancy.

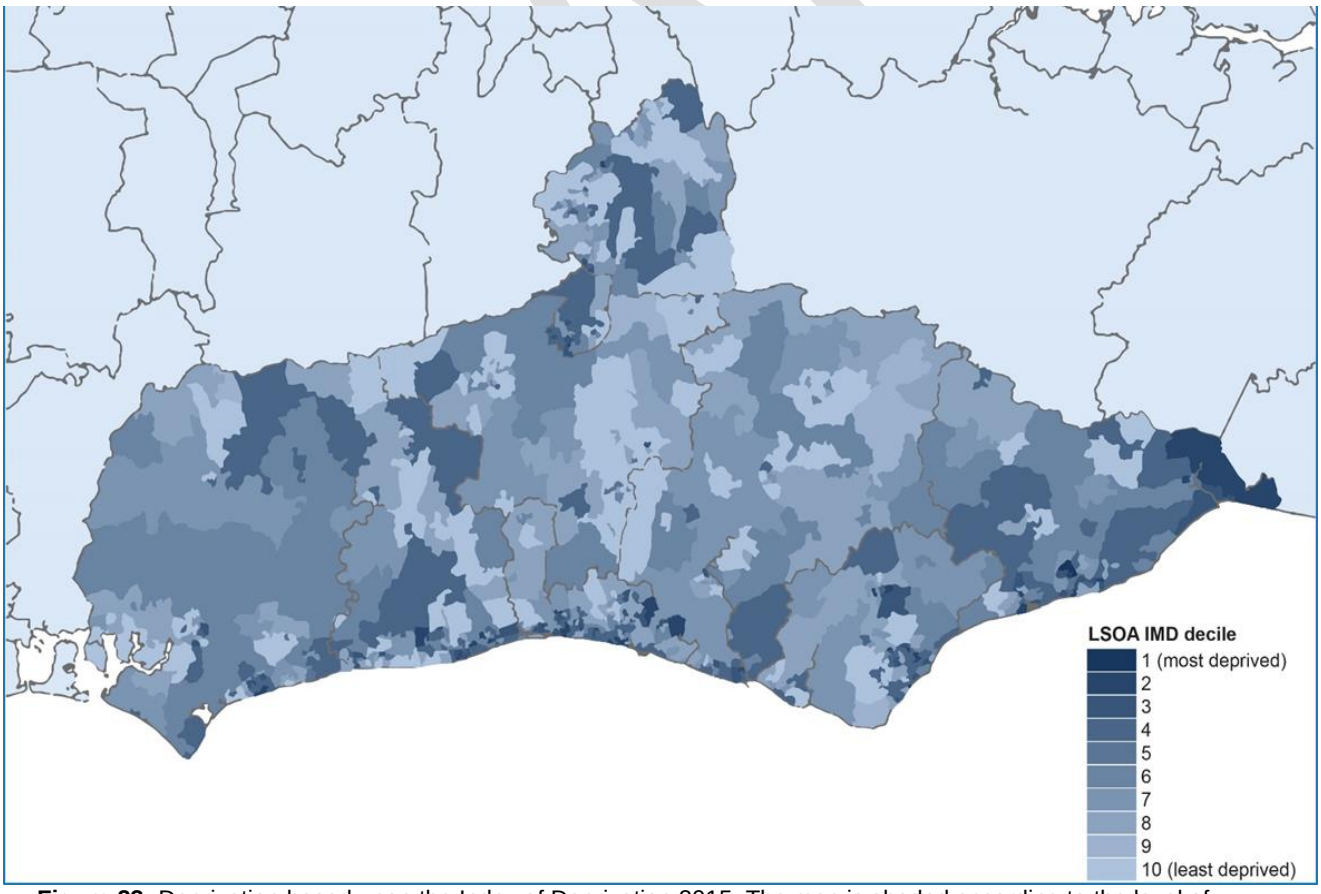


Figure 23: Deprivation based upon the Index of Deprivation 2015. The map is shaded according to the level of deprivation at neighbourhood level (Lower Super Output Areas). Areas shaded dark blue are some of the most deprived in England. DGLG Index of Deprivation 2015, Child Poverty rates HMRC as of 31 August 2015

6.2. Key drivers

There are a number of contributory factors driving this variation including: smoking rates; poor diet; lack of physical activity; alcohol misuse; and mental health problems. Action to address these needs to recognise the extent to which they are influenced by social and economic inequality and the wider determinants of health.

Modifiable risk factors (these can be reduced or controlled by intervention, and by doing so reduce the probability of disease)	Metabolic changes (biochemical processes involved in the body's normal functioning)	Long- term conditions
		
• Tobacco use • Physical inactivity • Alcohol and drug misuse • Poor diet (increased fat and sodium, with low fruit and vegetable intake) • Mental wellbeing	• Raised blood pressure • Raised total cholesterol • Elevated glucose • Overweight and obesity	• Cardiovascular disease • COPD • Diabetes • Cancers • Dementia

Figure 24: Modifiable risk factors and long term conditions

To ensure that prevention is embedded throughout the day-to-day work of the Partnership, the Prevention Board will work in collaboration with a number of Partnership-wide programmes on the implementation of primary prevention commitments, such as reducing smoking and alcohol misuse. Clinical programmes will lead on secondary prevention with support from the Prevention Board and we will ensure that pathways are joined up through delivery of local wellbeing services at place level. Preventative activities to reduce CVD are covered by the unwarranted clinical variation programme, whilst Children and Young Peoples' mental health is addressed by the Sussex-wide Mental Health programme and at place level, and cancer screening by the Surrey and Sussex Cancer Alliance. Please see relevant sections of the plan and Appendix A for further detail.

DRAFT

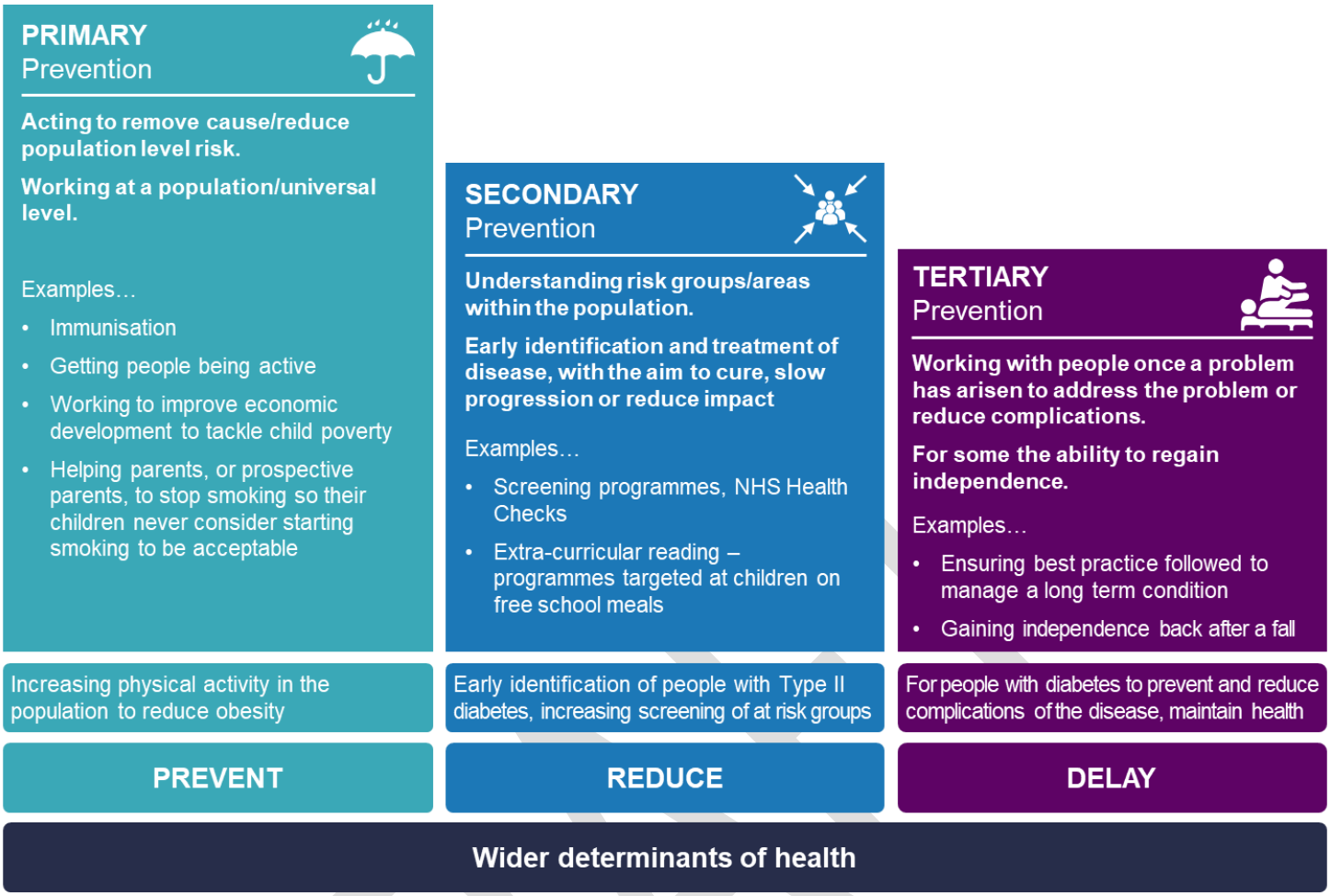


Figure 25: Definitions of prevention adapted from NHS England Population Health Management Flatpack

6.2.1. A whole-systems integrated approach

Public health interventions have an important part to play in stemming the tide of long term conditions and increasing costs. Focusing on an integrated life course approach to prevention is required to tackle health inequalities, with the greatest benefit yielded from work in the early years of life. At the same time, Sussex is developing a whole-systems approach to prevention that will be delivered through oversight of the Sussex-wide Prevention Board, and responsibility for local health and wellbeing strategies at place level.

As well as individual service interventions, public health interventions to build stronger and more resilient communities and places to support prevention and self-management are vital across the NHS, local authorities, the voluntary sector, community groups, and wider stakeholders. This is why the Prevention Board includes membership from local authorities, Sussex-wide workstreams, Acute Trusts, Public Health England, NHSE and the AHSN and Clinical Senate.

When considering the role of the community, we also need to understand whether interventions are best placed at a Primary Care Network (PCN) level, place level (local authority) or system wide, Sussex level.

At the Sussex level, we are committed to achieving a smoke free Partnership within two

years. We will also establish the role of NHS, Council and key partner organisations as anchor institutions, which is a term used to describe organisations whose long term sustainability is tied to the wellbeing of the populations they serve. Leading delivery of a healthy workplaces approach, and potentially an accreditation scheme for ICS organisations, is also a key responsibility of the Partnership. Across Sussex, we will develop a preventative ethos and culture across the health and social care workforce, by embedding an 'every contact counts' approach across the system.

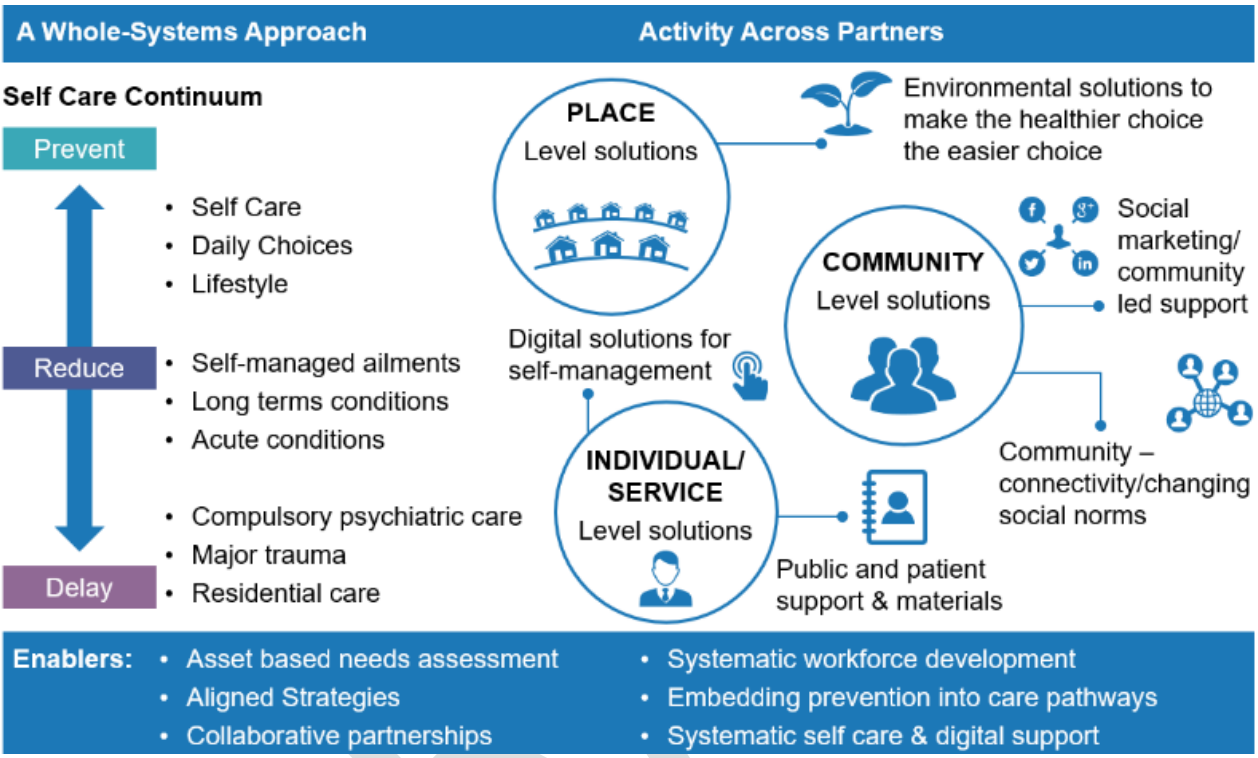


Figure 26: A whole systems approach to prevention

Our three places will support Sussex-wide prevention, but will have specific responsibility and to tailor and deliver:

- Early help services for young people and their families, including health visiting and school nursing
- Child and adolescent mental wellbeing and health services
- Adult social care support services
- Wellbeing programmes across each borough, including NHS Health Checks, as well as stop smoking services, increase physical activity, healthy diet and safe alcohol services
- Substance misuse prevention and treatment
- Sexual health prevention and treatment
- Approach to social prescribing services.

These actions will be supported by PCNs, which will contribute to our Sussex-wide commitment to prevention through:

- Identifying and targeting unimmunised children, young people and adults
- Identifying and targeting unscreened children and adults

- Making every contact count regarding smoking, alcohol, physical activity, healthy diet and mental wellbeing and referring people into health promotion and support services
- Embedding social prescribing across primary care services to support vulnerable adults and their families.

6.2.2. Five year vision

We are taking the opportunity of the Long Term Plan both to respond to key targets and to go further in galvanising the system around the ambitions to take a broad approach to prevention across Sussex and to integrate prevention activities within specific clinical workstreams. For more information on a number of preventative activities, please see sections 7.2 on Cancer, 7.4.5 on major health conditions, 7.3 on Mental Health and 7.4.4 on Unwarranted Clinical Variation, as well as Appendices B-C for place-based contributions to programmes such as Ageing Well.

The Prevention Board has six key objectives to support our population at each stage of life, including:

- Supporting a good start in life, including delivering a whole systems approach to healthy weight, and promoting emotional wellbeing and good mental health in children and families
- Improving the health and wellbeing of working people, for example, through the development of workplace programmes across Sussex
- Preventing the development of long term conditions (LTCs) through primary prevention programmes focused on the major causes of ill health.
- Improving health outcomes for people with LTCs including cancer, cardiovascular disease, diabetes and mental health conditions, through a staged approach of early detection, support for self-care and robust clinical management
- Supporting our population to age well by promoting both physical health, for example through falls reduction programmes, and mental health, through community-based programmes to alleviate isolation
- Recognising that a good death is as important as a good birth, and therefore supporting people to die in their preferred place of death, supported by the highest quality end of life care
- Taking an asset-based approach to supporting wellbeing, which focuses on 'what matters to people' rather than 'what's the matter with people'.[6] We will do this by strengthening social networks and communities, and maximising the impact of social prescribing to empower citizens to make healthier choices.

6.3. Key priorities to delivery five-year vision

The key priority for 2019/20 is to establish the Prevention Board, which is currently in a nascent state, and to develop a comprehensive strategy that links all our ambitions and workstreams together coherently. We will embed the expectation that all workstreams should

[6] Please see 'Our Population Health Check, A Clinically-led Diagnosis of What Needs to Change' for further details.

be prioritising prevention, and sign off this Partnership-wide improvement programme involving all partners by 2020/21.

The Sussex Partnership is committed to prioritising prevention, which is demonstrated by the approach that prevention is not just the responsibility of the Prevention Board, but of all workstreams. This committment is demonstrated by the allocation of 30% of 'Other' Fair Shares funding from the Long Term Plan to preventative activities from 2021/22 – 2022/23, and 20% in 2023/24. This is a higher percentage than recommended by NHSE and will be used to support our current priorities and those determined through further strategic planning over the following year. Please see the Strategic Planning Tool for further detail on the allocation of Fair Shares funding by provider.

For 2020/21 our initial four priorities at Sussex level are:

- To achieve a smoke free ICS by 2021 by scaling up Stop Smoking Services and Smokefree NHS Trusts
- To establish the role of the NHS, Councils and key partner organisations as anchor institutions to influence the wider determinants of health
- To maximise the workforce contribution to prevention by facilitating a shift in culture so that prevention is everyone's responsibility, and to upskill our workforce for this
- To develop and roll out a Healthy Workplace Programme to include support for active travel, healthy eating and physical exercise. This may potentially include a workplace accreditation scheme for ICS organisations.

Priority prevention areas are detailed below, including specific actions, funding, outcome metrics and targets. For further information, please see Appendices A, B, C and D for some five year phasing and place-based commitments supporting Sussex-wide work.

6.3.1. Smoking

Given that Crawley, Brighton & Hove, and Hastings & Rother have a smoking prevalence above the national average, these are the areas where we would target our smoking cessation programme for inpatients. We would pilot our smoking cessation programmes for inpatients from 2020/21, potentially starting with maternity and mental health patients, working in partnership with the Local Maternity System (LMS) and Mental Health Programme, before subsequent full roll-out.

CCG	Smoking prevalence % (GP patient survey 2018)
England	14.6
Sussex	13.9
Crawley	**16.8**
Brighton and Hove	**16.5**
Hastings and Rother	**16.4**
Eastbourne, Hailsham and Seaford	13.1
Coastal West Sussex	13.0
High Wield Lewes and Haven	12.0
Horsham and Mid Sussex	11.0

Figure 27: Smoking prevalence by CCG

This would be based upon the Ottowa model, and the general smoking cessation programme has been modelled at between £274,805 and £347,395 for total acute costs excluding ongoing NRT, based upon services offered to all patients and an expected uptake of 27% based upon previous trials.[7] Dedicated programme managers will oversee the planning and delivery of a smoke free ICS by 2021. We are committed to using the Fair Shares funding allocated to prevention to support the smoking cessation for inpatients and pathways into community services. For more information, please see Appendix A.



Figure 28: Smoking priority areas

[7] See 'Hiding in Plain Sight', British Thoracic Society Audit

6.3.2. Alcohol

We know that alcohol misuse is significant in Hastings & Rother, Brighton & Hove and along the coastal strip in West Sussex, particularly for our younger populations. Therefore, we believe that there is a strong case for investment given the level of need and the cost-effectiveness of interventions around alcohol care teams.

CCG	Admissions episodes for alcohol-specific conditions – Under 18s (crude rate per 100,000 2015/16-2017/18)
England	32.8
Sussex and East Surrey	37.8
Hastings and Rother	**54.4**
Brighton and Hove	**51.9**
Coastal West Sussex	**38.0**
High Weald Lewes Havens	**34.8**
East Surrey	**33.5**
Eastbourne, Hailsham and Seaford	30.9
Horsham and Mid Sussex	28.8
Crawley	24.9

Figure 29: Alcohol related admissions by CCG

As an ICS, we recognise that, irrespective of national ranking, alcohol misuse not only affects the health and wellbeing of large numbers of residents but also places considerable pressure on health and social care services. We would target alcohol care teams at BSUH, Conquest Hospital in Hastings and Worthing Hospital in Coastal West Sussex (CWS) with service models tailored to local needs, which would likely be 7-day services at an estimated cost per setting of £165,000-£180,000.

DRAFT



Figure 30: Alcohol priorities

6.3.3. *Obesity*

Diet, nutrition and physical activity are key priority areas for primary prevention to reduce the prevalence of long term conditions such as cancer, cardiovascular disease and diabetes within our population.

CCG	Obesity % (QOF prevalence (18+) 2017/18)
England	9.8
Sussex and East Surrey	7.8
Crawley	**10.8**
Hastings and Rother	**10.0**
Coastal West Sussex	8.8
Eastbourne, Hailsham and Seaford	8.1
High Weald Lewes Havens	6.7
Horsham and Mid Sussex	6.6
East Surrey	6.3
Brighton and Hove	5.5

Figure 31: Obesity prevalence by CCG

We are undergoing an options appraisal for a Sussex-wide Tier 3 service to ensure equity of access to weight management services, and further measures to manage adult and childhood obesity will be considered as part of our detailed strategy development during 2019/20 and 2020/21.

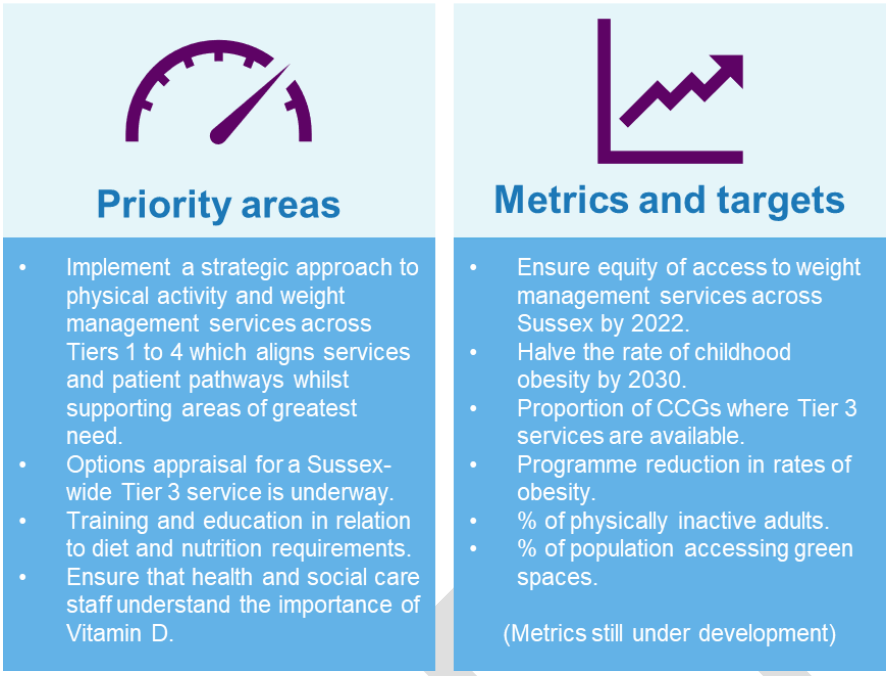


Figure 32: Obesity priorities

6.3.4. Immunisations

Although our immunisation rate of 92.3% across Sussex is above the English average, only one of our CCGs currently reaches the 95% target required for effective herd immunity. The causes are multifaceted and include misinformation, access, and a lack of awareness about disease prevention. This places our population at risk of preventable diseases and is a local priority for Sussex given a number of recent measles outbreaks coinciding with the World Health Organisation removing the UK's measles elimination status.

CCG	MMR vaccination for one dose (2 years)
England	91.3
Sussex and East Surrey	92.3
Horsham and Mid Sussex	95.9
Crawley	**94.7**
Coastal West Sussex	**94.1**
Eastbourne, Hailsham and Seaford	**94.1**
Brighton and Hove	**91.3**
High Weald Lewes Havens	**91.3**
Hastings and Rother	**90.3**
East Surrey	**84.8**

Figure 33: MMR vaccination rates by CCG

To achieve our aim of reaching a 95% immunisation rate for the second MMR vaccination, we will support all PCNs to identify and put more support in place to reach unvaccinated children. We will promote joined-up working between the Vaccinations and Immunisations team, commissioners and the Prevention Board. Working with the Screening and Immunisations team, we will address health inequalities in screening and vaccination

programmes through the identification of variation and under-represented groups, through Health Equity Audits and specific targeted interventions for key groups and for geographical areas where there are identified inequalities, such as in Hastings & Rother.

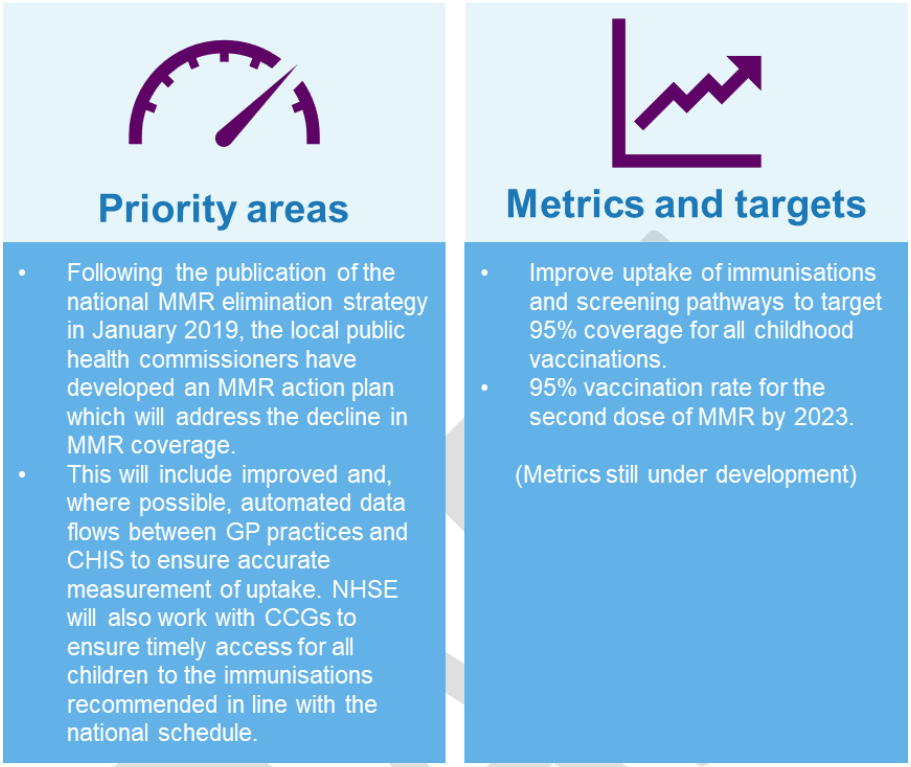


Figure 34: Immunisation priorities

DRAFT

6.3.5. Further programmes

Additional areas of focus for the Prevention Board are detailed below, including primary prevention as detailed in our strategic delivery plan under section 7.2 on cancer and 7.3 on mental health. These areas will be further considered during the development of our comprehensive prevention strategy over the following year.

Health inequalities	• Identify gaps and develop targeted plans taking a proportionate universalism approach at place level in relation to the largest local drivers of inequalities. • Align priorities and plans with the three place based Health and Wellbeing Board strategies. See Appendices B, C and D for more information on place-based prevention priorities. • Maximise our role in sustainably addressing the wider determinants of health – as an employer, commissioner and contractor. • Increase public awareness by improving approaches. For example, 'Making Every Contact Count' and health checks. • Work with PHC who will carry out Health Equity Audits to address inequalities in screening and vaccination programmes with specific targeted intervention for key groups and geographical areas.
Cancer screening	• Supporting the Sussex Cancer Board and Surrey and Sussex Alliance in development and implementation of their 5 year strategy around screening, including through Local Commissioned Services (LCSs) at place level. • Universally delivering new screening tests, rapid diagnostic services and improving uptake amongst populations with the lowest rates of uptake. For bowel screening, this is Crawley CCG (52.5%) and for breast and cervical this is Brighton & Hove (65.9% and 68.2% respectively).
Children and young people	• Systematic NHS approach to children's prevention and treatment pathways, including adopting family-based approaches across the NHS. • Childhood obesity programmes at place level, including sugar reduction and physical activity in schools. • Child and maternal health, including safe places to live and grow up, in collaboration with the Local Maternity System. • Strengthen action to address emotional and mental wellbeing of children and young people through close collaboration with the well-developed Sussex Mental Health Programme.
Healthy and sustainable places and communities	• Implement the NHS action plan on air quality through the Sussex Air Quality Partnership (Sussex-air) which is well established in supporting Sussex authorities with their duties under the Environment Act 1995. This work will largely be delivered at place-level through local air quality strategies, such as the West Sussex 'Breathing Better' strategy developed in May 2018. • System wide and place level approach to enablers of healthy communities, including housing, green spaces and arts.
Mental health	• Mental health education in schools to promote resilience. In 2019/20, there will be 7 Mental Health Support Teams in Schools in Sussex and we will support the Sussex Mental Health programme to cover between a quarter and a fifth of Sussex by 2023/24. • The Mental Health Programme is developing a suicide reduction programme, including self-harm, for full implementation from 2021/22. Suicide bereavement support services will also be available across Sussex by 2023/24. See Appendix A for more detail. • Develop a joint mental health / prevention strategy across the Sussex Partnership in 2020/21 ensuring this strategy integrates with place-based commissioning and provisioning around wider local services for substance misuse, housing and homelessness.

Antimicrobial resistance	• The commissioning quality team has developed a two year clinical strategy for infection prevention. This will take a system-wide approach to reducing health care associated infections (HCAIs) through close provider and commissioner collaboration aiming to:
	  • reduce key alert organism gram negative bacteraemias by 50% by 2024
	  • reduce inappropriate antimicrobial usage
	  • adopt national campaigns such as Target
	  • comply with the National Quality premium/CQUIN antimicrobial targets.

6.4. Governance

The Sussex Prevention Board will take a Population Health Management approach to improve healthy life expectancy and reduce dependency on health and care services through a radical upgrade in prevention, early intervention and self-care. The Board will seek to take a common approach where working together as a system would add value to improving prevention and reducing health inequalities, for example, with regards to smoking, alcohol misuse and weight management services. However, other action to coordinate prevention will still take be undertaken at place level, such as delivering local Health and Wellbeing Strategies. The Board includes membership from other clinical workstreams, such as the Mental Health Programme, CVD and MSK programmes, and the STP Cancer Board, with clinical leadership to jointly chair the board with the Directors of Public Health. The role of the Prevention Board will be to:

- Coordinate and maintain oversight of the Sussex prevention plan.
- Agree the programme plan and priorities of the workstream programmes.
- Promote strong and effective co-production in the development and implementation of the programme, ensuring inclusion of the views of service users and their families and carers.
- Monitor outcomes and trajectories of reporting programmes and support them to overcome challenges escalated.
- Advise and identify innovative, cost effective, evidence based and affordable solutions for achieving progress. Identify a range of existing and potential levers for securing investment.
- Bring together the input of local NHS organisations, Public Health England (PHE), NHSE and Local Government Public Health to ensure maximum efficacy around prevention.
- Embed prevention priorities in individual organisations, local delivery systems, and across other Sussex-wide workstreams.
- Link to Health and Wellbeing Boards across the three Sussex places.

DRAFT

6.5. Interdependencies

Core interdependencies are shown in the table below. The Prevention Board will work closely with these workstreams in developing and embedding prevention throughout Sussex.

Workforce, people and culture	• There are existing workforce challenges in breast radiology and radiography, endoscopy, histopathology and colposcopy which all need to be addressed through workforce planning. • Universal commitment to, and understanding of, the opportunities and benefits in relation to prevention. • Workplace health and wellbeing – systematic approach across all ICS organisations. • Cultural change around embedding the relevance of prevention to all clinical workstreams. • Embed 'Making Every Contact Count' in job descriptions across the health system. • Maximise the role of the NHS in addressing the wider determinants of health.
Digitalisation IMT and analytics	• Support people to use their personal health data for prevention. • Population health management to inform the timing and nature of prevention interventions, supported by integrated health and care records. • Consistent messaging and approach on prevention delivered through Apps. • Improved data exchange between primary care and A&E. • Capability to track interventions in relation to prevention. • Data analytics to measure and compare outcomes.
System financial management	• Transfer resources towards prevention and away from treatment on an incremental basis which aligns with the shift of resources from acute to primary and community care. • Defining financial model for prevention to align with QIPP.
Cancer Alliance and LMS	• Improve breast, bowel and cervical screening uptake. • Improve childhood and immunisations screening to meet minimum standards consistently across Sussex.
CVD, Falls, MSK and Mental Health	• Primary prevention programmes focused upon these major causes of ill health. • Empower citizens to remain independent in their own homes and to be supported by their communities in doing so.
Sexual Health	• Maintain and enhance an integrated approach to sexual health pathways in line with the aspirations set out in the LTP.

7. Our transformation priorities

7.1. Developing a new service model centred around place-based joined-up care

As set out in the Sussex Health and Care strategic model in section 3.2.7, places will provide joined-up primary, community and local hospital services in the local area such that services can be designed around individuals and allow for seamless movement between primary and community health, social care, and local hospital services in a timely and efficient manner.

Responsibility has been devolved to the places for service transformations and delivery in the following areas:

- Transforming out of hospital and community-based care
- Reducing pressures on urgent and emergency care
- Giving people more control over their own health and more personalised care
- Reducing waits for planned care
- Effecting digital transformation of primary care and outpatients.

This chapter sets out the common principles behind place-based plans in these areas – full detail of the place-based plans, including but not limited to more detailed implementation plans for the areas above, are in Appendices B, C and D. Appendix A contains the line by line responses to the LTP commitments, and place-based detail can be found in tabs "Brighton & Hove", "East Sussex" and "West Sussex".

The full place-based plans have been written by the "system" of partners in each of the places, comprised of acute, community, and mental health providers, commissioners and local authorities. Each of the place-based plans is locally owned and reflects the health and care needs of the local population, with specific local priorities and implementation plans to reflect local need. There has been a significant degree of engagement across the "system" of partners in each place in the development of these plans, which has not consistently happened before. Plans also address the development needs for the governance in each place, which varies dependent on maturity of relationships.

Places also play a crucial role in the implementation and delivery of Sussex-wide strategies, such as prevention, mental health and cancer. The role of places in these areas, where strategy is set Sussex-wide, is to implement and deliver the strategy where the appropriate level of delivery is "place" (as opposed to complex or specialised services delivered Sussex-wide), and to localise specific areas of planning where local need dictates a different approach for each place. Place-based plans set out the implementation and localisation of Sussex-wide planning, with the degree of detail and ambition reflective of the local prioritisation for each place.

Places have also taken the lead on the development and articulation of planning around services for Children and Young People (see section 6.5.2) and Respiratory (see section 6.5.5).

7.1.1. Transformed out of hospital and community-based care

Faced with an ageing population who have multiple long term conditions, we intend to provide an integrated model of care that focuses on keeping our population out of hospital when an acute environment is not the most appropriate location for care, while looking to the community as a key location where more of our care will be delivered.

Integration is a core component of transformed community-based care. Places are supporting the development of their PCNs (see section 4.3) and are developing the model and ways of working between primary and community care around PCNs. Places have worked closely with local government through the Better Care Fund and have seen good whole system performance against the Better Care Fund targets. We will continue to use this to introduce services changes in line with the commitments from the Long Term Plan, such as the Carers' Hub in Brighton & Hove.

As part of our commitment to our ageing population and our view to integrate services and move care into the community, we intend to work across acute providers, community and social care to reduce the volume of DTOCs (delayed transfers of care) in our system, ensuring that our population receive the right care in the right place at the right time.

We are addressing four key priorities within community care, as laid out in the Long Term Plan: improved crisis response within two hours and reablement care within two days; anticipatory care jointly with primary care; supporting primary care to develop Enhanced Health in Care Homes and developing a carer-friendly NHS. Places have been asked to develop their own plans within these areas which support our Sussex-wide strategy whilst being responsive to local needs. Full timelines for transformation of out of hospital and community-based care can be found for each place in the Appendices.

Priorities within community care are also all strongly linked to the Sussex-wide unwarranted clinical variation programme focusing specifically upon CVD, MSK and falls and fractures. See section 7.4.4**Error! Reference source not found.** for further detail.

Improved crisis response and reablement

There is some variation across Sussex in delivering crisis response within two hours based on historic commissioning and system arrangements. However, some areas are delivering this already and we will build on this strong foundation to ensure all services can meet this requirement consistently across Sussex.

Ensuring areas have effective and efficient single points of access to crisis response and reablement is also vital to their success. Whilst there is some variability in infrastructure across Sussex to provide this, many areas have or are already moving to single points of access which will underpin multidisciplinary crisis response.

The system-wide Step-Up Step-Down Programme focuses on the clinical, rehabilitation, and reablement models required to support care closer to home by aligning and clarifying roles for provision of a more integrated model for community crisis response and reablement. Alongside this, we are focusing on methods to improve discharges, through the roll-out of Home First pathways and Integrated Discharge Teams, for example. In addition, crisis response teams will also play a role in admission avoidance and therefore contribute to reduced pressures on emergency services, as set out in section 7.

The Community Services Dataset is a fundamental building block in unlocking the full

potential of clinical and digital transformation, by allowing community service providers and commissioners to view local and national information from community services. Places have local plans to improve local system usage.

For full detail of implementation of crisis response and reablement in each place, please see the Appendices.

Anticipatory care

Anticipatory care is a key deliverable for Primary Care Networks. In bringing General Practice and community services together around populations, we can build on existing Community of Practice models across Sussex and support people to make informed decisions about their own care as well as receive timely support from local services.

We have learned that where this approach is most effective it is built on evidence-based risk stratification. We will be enabling places to secure the right systems to underpin this through commissioning and system-wide digital solutions.

Patients supported through anticipatory care will each have a clear plan built around their needs which aims to avoid unnecessary admissions and deterioration, not only for the most high-risk patients but also for those at risk of future ill health. Anticipatory care plans will include: named point of contact, normal observations, and contingencies to ensure that patients/professionals know what to do pre and during crisis to manage their conditions and situations. These plans will be shared across all services to ensure that however and wherever a patient presents the plan will be enacted. Patients approaching end of life will also be supported through advance care planning to make joint decisions relating to preferred place of care and death to improve experience and reduce invasive interventions which focus on prolonging life rather than quality, comfort and dignity.

For full detail of implementation of anticipatory care in each place, please see the Appendices.

Enhanced Health in Care Homes

There are a number of Locally Commissioned Services for Enhanced Health in Care Homes already in place across Sussex which will support our ambition to enable our population to age well. This programme will utilise collective General Practice and community services through Primary Care Networks and aims to reduce acute hospital admissions by enabling better early identification and forward care planning. The places are working with their partners to further roll-out these services across nursing and residential care, including by providing training programmes for care homes. We will ensure that there is place-wide and consistent coverage of these services, but also that support to develop these services is targeted at areas of most need.

Further support is being provided to care homes, such as assistance to register for NHS.net email addresses and complete the Data Security and Protection Toolkit to enable care homes to register for a shared mailbox.

For full detail of implementation of Enhanced Health in Care Homes in each place, please see the Appendices.

A carer-friendly NHS

To deliver integrated community health and social care, we need to support all members of our population and the better identification of carers is key to this commitment. We need to provide better information and support to carers through a variety of methods including single points of access to dedicated carers' services, digitally-enabled solutions such as the Jointly app funded by Brighton and Hove City Council and the CCG, which enables carers to store and share all the important information about someone they care for with professionals and across organisations, and health support such as the Carers Health Team in West Sussex. Our places will also consider how commissioning of carer identification and support can be extended into the primary care setting to be delivered in collaboration with PCNs as part of the implementation of Universal Personalised Care.

For full detail of the implementation of a carer-friendly NHS in each place, please see the Appendices.

7.1.2. Reducing pressures on urgent and emergency care services

Reducing pressures on urgent and emergency care services

Urgent and Emergency Care (UEC) should be focused on unplanned incidents and, in the case of emergency care, is the highest escalation point of patient care. However, all too frequently our A&Es are seen as the default alternative for gaps in the provision of or access to other services, resulting in rising demand, departmental overcrowding and long delays for patients.

Over the next five years, we will continue to develop our strategic networked model for urgent care that delivers fully integrated services, is aligned across the Sussex footprint, and meets the needs of the whole patient population. We will focus on pre-hospital and Same Day Emergency Care (SDEC) interventions to target a reduction in A&E referrals and admissions, and ensure patients are seen in the most appropriate setting.

Current state and challenges

Our community, acute and primary care services are fragmented and can be very different across commissioning group boundaries. This is not helpful for patients and makes services unsustainable both financially and for our work force.

In line with the national trend, our emergency care system is under real pressure. Attendances at our A&E Departments continue to rise with a 13% overall increase in demand on our acute trusts over the last year. Our ambulance services are facing significant handover delays at our A&Es, increasing cycle times and 999 response times for our patients.

For example, between 24th Dec 2018 and 2nd Jan 2019, SECAmb lost in excess of 1,800 operational ambulance hours to turnaround delays greater than 30 minutes. This was a 43% decrease over the same period of the previous year; however, this is still equivalent to losing eight ambulances on duty every day of this 10 day period.

All of our acute trusts have service improvement plans in place with trajectories established towards achieving the 4-hour target; however, increasing demand across all areas in the system means that this remains a challenge. Whilst individual trusts occasionally meet the 95% 4-hour A&E waiting time standard, as a whole the Sussex Health and Care Partnership has not met the standard since it was formed in late 2015. The move of focus to clinical urgency that is expected from the Clinical Review is welcome, both from a clinical safety perspective and as an enabler to better influence patient behaviours towards alternative, more appropriate care pathways. We look forward to working with the regulator to baseline current performance and agree consistent interventions and enablers to achieve the new targets, in line with the commitment that systems will be supported to achieve the new access standards set by the Clinical Review.

Pre-hospital urgent care

Our goal is to ensure patients receive the most appropriate care in the most appropriate setting. For many patients this is not A&E, and improved access to effective pre-hospital care, including primary care services, will reduce emergency attendance and admissions. Our key priorities for pre-hospital care are shown below.

NHS111-CAS	• Increase ability to directly book appointment with an appropriate Health and Care Professional (incl. GPs, community services and UTCs) • Improve outcomes from of NHS111-CAS to increase 'consult and complete' capabilities, reduce levels of ambulance and A&E referrals and increase self-care dispositions • Undertake public engagement to improve awareness of alternatives available for the provision of care and increase use of NHS111-CAS
A&E Attendances	• Deliver and maintain Carter review recommendations in ambulance services to meet Ambulance Response Programme (ARP) targets incl. avoidable ambulance conveyances • Develop the CAS as the SPoA for patients, carers and HCPs accessing integrated care services, support admissions avoidance and facilitate hospital discharges • Increase the volume; quality and accessibility of anticipatory care plans to reduce unnecessary conveyances and admissions to hospital; • Develop shared workforce models (e.g. rotational paramedics) working across GP practices; EOC and on scene and extending to other appropriate urgent care services e.g. UTCs, CAS and Home Visiting to improve outcomes at the point of contact. • Extend care pathways in the community and increase capacity in out of hospital and responsive services to keep people at or closer to home;
Integrated Services	• Implement the Urgent Treatment Centre model so that all localities have a standardised offer for out-of-hospital urgent care • Work in partnership with Primary Care Networks to establish consistent place based integrated models of care • Transition to and imbed new ways of working as digital solutions, NHS111-CAS, PCNs start to impact patient demand and flow • Aligning and increasing admissions avoidance and discharge enablers (including patient transportation) to improve hospital flow and reduce admissions and lengths of stay. • Focus on and improve levels of Long Length of Stay (LLoS) patients and Delayed Transfers of Care (DTOCs) working collaboratively with local authorities and out of hospital services.

DRAFT

Same Day Emergency Care (SDEC)

Our Population Health Check estimated that over a quarter of all attendances at A&E could have been treated at another suitable location. Across our footprint we have significant variation in patterns of hospital use and admission, with Coastal West Sussex CCG (CWS) and areas of East Sussex showing levels of hospitalisation almost four times as high as in other areas of the Partnership.

Our focus will be to increase the provision and capacity of SDEC services, aiming to deliver consistent services for 12 hours per day, 7 days per week by September 2019 and 30% of non-elective admissions via SDEC by March 2020.

Particular challenges exist with SDEC services being used as A&E overflow areas to reduce overcrowding. We are working with providers to support operational improvements in flow and better manage demand to enable the consistent delivery of these services, with particular focus on reducing conveyances and ED referrals by ensuring patients are directed to the right service to meet their need.

In support of effective SDEC services, we are working with clinicians across the footprint to develop standardised care pathways that extend into the community and scale admissions avoidance initiatives. For example, developing a Health Care Professional (HCP) Single Point of Access (SPoA) solution will provide a rapid, easy-to-access resource to support clinicians in identifying alternative and more appropriate pathways of patient care.

Reducing avoidable conveyances

There are a number of different workstreams and priorities that will contribute directly to our ability to reduce ambulance conveyances. These include:

- Developing SDEC services that support direct referrals
- Improving crisis response services in the community to enable more patients to be treated at home
- Developing DoS and Service Finder solutions to present crews with appropriate alternatives
- Increasing the volume, quality and accessibility of anticipatory care plans
- Developing an ambulance crew workforce and operating model to ensure crews can access experienced crew members to validate conveyance decisions.

Governance and performance

To support continued delivery against our priorities, performance against improvement trajectories will be monitored through Local A&E Delivery Boards and overseen by the SHCP Executive. Issues and risks that need to be considered at scale will be escalated through the UEC Steering Group.

A single strategic commissioning function will be established to coordinate commissioning activities, applying a consistent set of principles and common ways of working across Sussex. Whilst implementation, relevant service customisation to match patient need, and delivery will be owned in each place, models of care will reflect the strategic approach agreed for Sussex.

We will need to develop governance and leadership structures to reflect the needs of the Sussex Integrated Care System (ICS) and new reporting arrangements to reflect the requirements of CCGs, PCNs, providers and regulators as the new operating model lands and delivery against the plan progresses.

Delivery planning

A summary of our UEC transformation plan is shown in the figure below

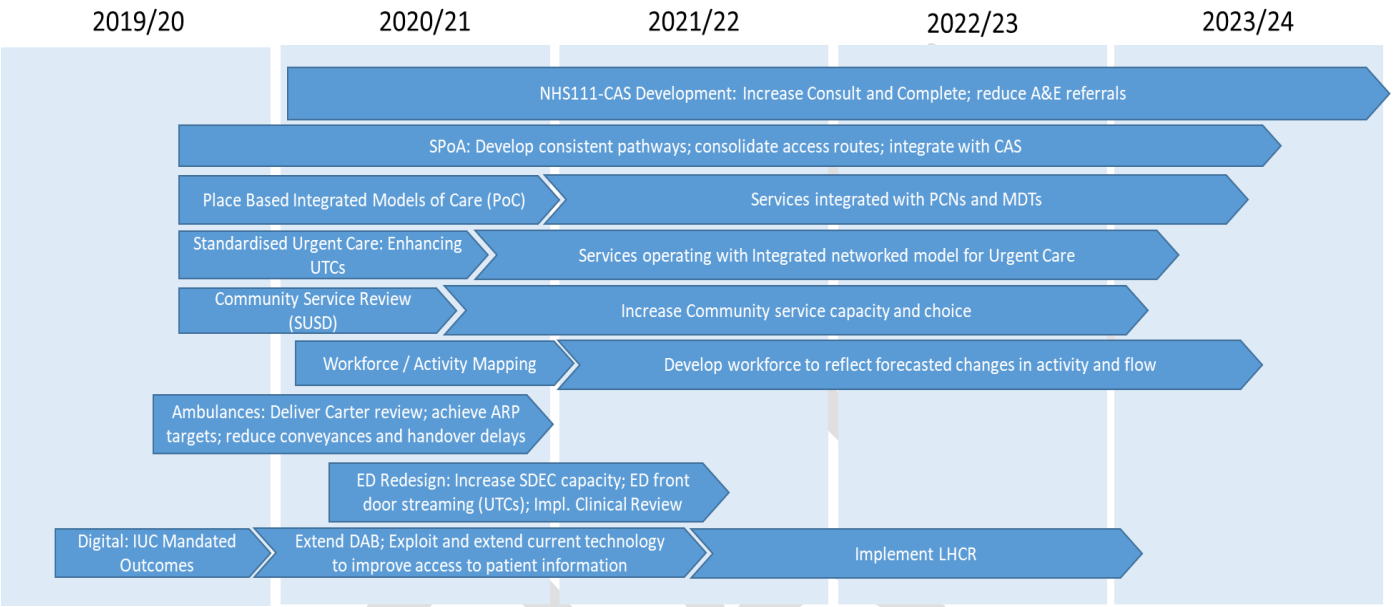


Figure 35: Summary of our Sussex UEC transformation plan

Public engagement

The forward delivery of urgent and emergency care services is supported by an SHCP communications and engagement strategy, developed:

- To ensure patients have the information and support to make informed choices about their health care, providing them with a toolkit of options when they or a family member become unwell
- To increase positive awareness and understanding of the right services to use for the right health concerns – services to highlight include NHS 111/CAS, Urgent Treatment Centres, Integrated Primary and Community Service, GP Improved Access
- To increase positive awareness of other supporting services such as pharmacies, social care and third sector charities
- To encourage patients to use the appropriate service depending on their health care needs
- To reduce pressure in urgent care by promoting the ways in which minor illness can be treated at home
- To enhance patients' confidence and engagement in their local health care service, by offering consistency across the SHCP footprint to reduce current confusion.

All communications and engagement activity will be planned and delivered in a targeted way that maximises impact across the patient population.

Digital enablers

Technology, system interoperability and our ability to share patient information appropriately are key factors in delivering the integrated services described for urgent and emergency care, and the trajectory to achieving the required level of digital maturity across Sussex is understood.

Work is already underway across the SHCP to make it possible to share patient data and care plans across different GP, hospital, ambulance and social care systems, exploiting existing infrastructures and technology.

Delivery of the Local Health Care Record (LHCR) will establish a strategic delivery mechanism to meet this challenge. However, full implementation is subject to funding, and remains dependent upon national solutions, such as GP Connect, which are required to deliver strategic solutions for access to structured patient data.

Focus will continue to be applied to gaining population insight using tools such as SHREWD to inform operational priorities and strategic direction, and identify system resilience pressures.

Workforce enablers

Workforce remains the biggest risk across the system. To mitigate this, the UEC strategy and plan is predicated on integrating services to remove duplication across pathways so that we can increase efficiency and productivity within our existing workforce.

Understanding the workforce needs of the future is dependent on having robust mechanisms for measuring the impact of services changes on activity and flow. Workforce models will be developed to measure and forecast our future needs to support our networked model for urgent care.

Priority will be given to developing a competencies-based approach to achieving the required patient outcomes. This will allow us to develop and enhance our existing workforce in advance of the longer-term role development, training and recruitment plans starting to take effect.

Further interventions will be determined and developed in the operational planning phases of implementation.

Estates enablers

The Estates Strategy has been developed with significant input from the Urgent and Emergency Care workstream to ensure future needs are reflected in capital investment projects. This is with regard both to the direct provision of UEC services and to the transformation of out of hospital and other enabling services that will contribute to the required changes in patient flow and the management of demand.

Estates Strategy priorities that specifically reference and support Urgent and Emergency Care, and services that the delivery of our networked model for urgent care depends on are as follows:

1. Out of Hospital care
2. Urgent and Emergency Care services
3. Construction of BSUH 3Ts.

7.1.3. Giving people more control over their own health and more personalised care

At the core of our health and care strategic model is the role of personalised care in facilitating choice for our patients and population, who are often experts in their own care. They expect clear information about what treatment involves, the evidence that it works, the outcomes it will achieve, and what happens next. We believe in personalised care that means our population have choice and control over the way their care is planned and delivered, based on "what matters" to them and their individual strengths, needs and preferences.

The NHS Comprehensive Model of Personalised Care sets a clear ambition as to how we as a system can support patients by delivering tailored and truly personalised care. These actions are part of our comprehensive approach to prevention and reducing health inequalities across Sussex.

Component of NHS Comprehensive Model of Personalised Care	Actions to be taken
1. Shared decision making	Across our places, we are investing in and assessing the progress of sharing decision making, to ensure that our population understand their options and make an informed decision that reflects their personal preferences. At the heart of our approach of shared decision making is learning from existing shared decision making approaches in MSK and embedding them across all areas of elective care. Brighton & Hove are also embedding the Make Every Contact count approach in the shared decision making process, West Sussex are establishing shared decision making and working with the local authority, and East Sussex are utilising Patient Activation Measures (PAM).
2. Personalised care and support planning	We are working with local authorities to develop choice further, and discussions on preferences for future care are being built into pathways, with patients setting individual activation levels and goals. We will develop plans for Personalised Care and Support Planning with our local authorities, first identifying which patient cohorts and which pathways to prioritise in the first phase. Our aspiration to increase the number of active (new and reviewed) in-year Personalised Care and Support Plans (PCSP) over five years is set out in the Collections Tool.
3. Enabling choice, including legal rights to	Choice has been an integral part of our patient offer for a number of years, which we will continue to promote at the point of referral,

choice	including through the development of Single Referral Pathways and the Referral Support Service in West Sussex.
4. Social prescribing and community-based support	We will seek to develop a coherent social prescribing approach that is aligned across each of our places, developing existing local initiatives in affiliation with community development organisations and aligned to the incoming social prescribing link workers at PCNs. We will have shared outcomes, while allowing for local flexibility to respond to specific population needs. In Brighton & Hove, for example, the established service is being expanded to include PCN link workers, and work is underway to embed social prescribing along the patient pathway. Our aspiration to increase the number of social prescribing link workers and social prescribing referrals over five years is set out in the Collections Tool.
5. Supported self-management	Self-management is one of the building blocks of our health and care strategic model. Places will be reviewing the opportunities to collaborate with local authorities, ongoing projects and current patient pathways for greater development and integration of this principle in everyday delivery. Digital solutions are key to supporting self-management, with East Sussex looking at the utilisation of Patient Activation Measures (PAM) in service delivery to support self-management, and West Sussex using MSK Assist and myCOPD to support self-management.
6. Personal health budgets and integrated personal budgets	Further plans are being developed with the local authority to increase the number of, and spend on, personal health budgets. This will build on work done around personal health budgets for wheelchairs, following on from work done with the local wheelchair provider. Our aspiration to increase the number of personal health budgets over five years is set out in the Collections Tool.

We are aware successful implementation of personalised care requires effective leadership and an upskilled workforce, so will be working with workforce leads and colleagues across Sussex to further understand the workforce implications and needs to support the implementation of personalised care. We also appreciate the importance of the first-hand experience of our population and will seek to identify further opportunities to co-produce personalised care with people with lived experience in Sussex.

More detail on the implementation of the six components of the NHS Comprehensive Model of Personalised Care can be found for each place in the Appendices.

Personalised care is a key component of our approach to services and, as such, we have also addressed our approach to personalised care throughout our plans. See sections 6.2.6 for our plans for personalised cancer care and sections 7.2.4 for our personalised care products developed as part of our digital programme.

7.1.4. Reducing waits for planned care

Across the Sussex footprint, we are committed to reducing the delays patients face when accessing elective care, including for musculoskeletal conditions. This has been one of the greatest challenges faced by our system, as the time that patients have waited for elective treatment during 2018/19 has increased and exceeded the 18-weeks RTT targets and diagnostic targets across a number of our places.

Our elective services are currently commissioned from a wide range of NHS and independent sector providers in the region, as well as supporting referral further afield. Therefore, we need to prioritise working with all these system partners to implement our planned care improvement programme.

As a system, we have tasked each place to set out their plans to improve planned care, based on the following common principles.

Planned care principle	Actions to be taken
Ensure compliance with the 52-week RTT target and increase volume of planned surgery	• Increase elective care activity • Work to meet the diagnostic standard through improvements in referral criteria and demand management, booking efficiencies, diagnostic capacity increases, and delivery of Rapid Diagnostic Services with the Cancer Alliance • Work to increase theatre productivity and efficiency
Reduce waiting lists	• Release and re-direct efficiencies to enable elective care to be delivered in the most appropriate setting, including in primary and community care • Implement referral management initiatives, including Advice and Guidance for GPs, reducing unwarranted variation in elective referrals demand and outcomes • Reduce length of stay through GIRFT opportunities and targeted initiatives such as BSUH's specific support for super stranded patients with alcohol/substance misuse • Minimise activity with limited clinical value in line with Clinically Effective Commissioning (CEC) programme and adherence to national evidence-based interventions
Improve patient choice	• Expand digital and online services to improve patient choice, including offering more virtual outpatient appointments • Mobilise Capacity Alerts to sign-post patients upon referral in Primary Care to where there are shorter waits for planned care within the system • Work together to ensure that the 26-week wait policy is

	fully implemented by April 2020, developing an SOP, sourcing capacity and setting up an admin hub, to commence with a small pilot in December 2019
Support self-management and empower patients	• Scale up provision of First Contact Practitioners to enable faster access to diagnosis and treatment for people with musculoskeletal conditions and support more patients to effectively self-manage their conditions

Our plans for planned care aspire to change the profile of our planned care activity in Sussex, through our commitment to reduce face-to-face outpatient appointments and subsequently increase digital appointments, increase advice and guidance provision, and motivate activity shifts through implementation of 26-week wait choice policy. We do not yet have sufficient implementation detail to reflect this in current activity and finance modelling, but as we develop this we will reflect it in our overall activity and finance projections for Sussex.

Further detail on how we're addressing planned care challenges within MSK services is shown in section 6.5, alongside plans to reduce unwarranted clinical variation across the footprint. Additional detail on our plans to transform outpatient services are set out in section 6.1.5.

More detail on the implementation of planned care improvements can be found for each place in the Appendices.

7.1.5. Digital transformation of primary care and outpatients

Within the Sussex Health and Care Partnership, we believe that digital tools and new technologies will allow us to radically redesign how our local populations access and interact with their care. A key priority for us is the transformation of primary care and outpatient services to improve access and increase patient choice.

Primary care

The ambition set out in the LTP is for every patient to have access to online consultations by April 2020 and video consultations by 2021. Our intent is outlined below, with further detail provided as part of our Digital Ambition and plan in section 6.2, as well as in the Strategic Planning tool.

We have made a strong start towards achieving this goal, with East Sussex being an early adopter for a targeted Digital First primary care offer, co-designed with users and providers. The online consultations have a good uptake already, and the lessons learnt from this are being shared across the footprint to develop our standard offer.

Our goal is to offer a comprehensive portfolio of online consultations and triage, including video-based consultation, and we will support GP practices in tailoring this to meet their local needs. We recognise that GP practices will adopt and develop at different paces due to their local population demand, practice culture and the challenges they are facing.

We will draw on the lessons from our initial user-led co-design in East Sussex and the innovation and digital services developed locally across our system. For example,

developing the already well-regarded social prescribing offers from places and neighbourhoods and supporting them with strong digital offerings. In Adur & Worthing the digital offer is being co-designed and developed with the local authority on their low-code platform using their Same Room user-led design approach to meet the needs of citizens, clinicians and communities.

Outpatients

The NHS LTP includes an ambitious pledge to use technology to fundamentally redesign outpatient services over five years. The aim is to avert face-to-face consultations in order to provide a more convenient service for patients, free up staff time and save money against the expected growth in demand. This will reduce travel times for staff and patients, improve patient experience and reduce the carbon footprint of the system.

We will do this by increasing the use of digital tools to transform how outpatient services are offered and provide more options, better support, and properly joined-up care at the right time in the optimal care setting through virtual outpatient appointments. Over the next five years, patients will have the right to online 'digital' GP consultations, and redesigned hospital support will enable the digital transformation of up to a third of outpatient appointments.

We have already made progress:

- In 2019, Brighton & Hove piloted tele-ophthalmology using new technologies to change the approach to how we treat Age Related Macular Degeneration. This new approach enables specialist community optometrists to improve referrals, have them assessed remotely by hospital consultants and, where appropriate, provide review and routine follow-up without the patient needing to return to the hospital.
- In Eastbourne, Hailsham & Seaford, and Hastings & Rother, digital enablers have been used for managing diabetes correspondence and self-management.
- In West Sussex, our providers will all complete implementation of their first stage of digital outpatients, deploying access to letters and appointments through a Sussex-wide Personal Health Record solution.
- Across Sussex, we have delivered successful virtual clinics and digital offerings in fracture clinics, IBD and HIV services.

Further plans are in place:

- In Brighton and Hove, we are supporting development of primary care based tele-dermatology, allowing images and case symptoms to be reviewed by specialists prior to referral. This pre-referral review means many conditions can, using specialists' advice and guidance, be treated in the community without a visit to the hospital outpatient departments.
- In East Sussex, schemes such as Patient Knows Best and Virtual Fracture Clinics are looking to improve efficiency and the initial focus will be on ophthalmology, gynaecology, and urology. Plans are in progress to choose applications for virtual outpatient appointments after which specialties will be chosen.
- In West Sussex, we will deliver programmes around ophthalmology, urology, neurology and gastroenterology, expanding this to a Digestive Diseases programme in 2020-21.
- Phase 1 of the 3Ts Build Programme will support, and be supported by, outpatient transformation and new models of care.
- Plans are in place to establish a programme of work which will see the implementation of one-stop and straight-to-test pathways, virtual clinics, SOS follow-

up, and the use of alternatives such as telephone or Skype.

- We are developing the PHR-based Personalised Care Product offerings for risk stratified cancer follow-ups in breast, colorectal and prostate which, following successful tests in the system, will be expanded to all of Sussex over the next five years.

However, we are aware that these developments need strengthening and coordinating across the system to ensure the impact is maximised. Therefore, an outpatient workshop was set up in September 2019 with 28 representatives from NHSE/I, trusts, CCGs and the Partnership, to develop local action plans to enable the delivery of outpatient transformation across Sussex.

The local vision was defined as "*having the right clinicians, the right place to treat the patient, and the right outcomes against which to measure treatment where patients do not have to attend an outpatient appointment unless absolutely required to do so"*.

A number of further priority initiatives were identified, and suggestions developed for proposed next steps which will deliver our model for transformation of outpatient services.

Priority initiative	Proposed next steps
Analytics Partnership to utilise and embed data analytics in day-to-day management of outpatient care	• Baseline assessment of current digital maturity and delivery plans to understand mid/short/long term opportunities • Greater transparency in data sharing between CCGs, providers and the Partnership • Investment in data analytics skills training • Improved integration of IT systems and investment in IT performance capabilities to identify priority patients using risk stratification • Consideration of ways to measure success (such as appraisals) which include a data metric
Pathways Champion key tenets of pathway development across the local area	• Further work with providers and commissioners to establish which pathways could be most effectively redesigned • Partnership championing of pathways and support for a pilot / promotion of outcomes • Identification of and learning from best practice elsewhere using NHS England Elective online platform
Remote care Support organisations who are keen to employ remote care alternatives to traditional outpatient appointments	• Investment in systems/processes that could increase the number of patients able to access remote care • Partnership championing of and support for the piloting of several types of virtual clinic • Feeding back of outcomes / cascade across Sussex

DRAFT

Accountability and governance Partnership to act as a system leader to coordinate the changes across the system	• Governance group review/confirmation as priority initiative and allocation of resource to undertake key activities
Patient expectations Have honest conversations to manage patient expectations at a strategic level	• Involvement of Healthwatch in any strategic initiatives relating to patient communications • Creation of a Patient Public Representation (PPI) group which has a specific interest in outpatients • Development of an engagement plan
Building networks Forge operational links between mental health, community care and primary and secondary care clinicians	• Consideration of a reference group or consultation forum which covers all key groups
Models of commissioning	• Consideration of Aligned Incentive Contracts as a useful way of moving forward • Tariff and/or costings nationally to incentivise transformation shift from face-to-face to virtual appointments or reduce the need for appointments

Workshop participants agreed on the need for a **Sussex Outpatient Transformation Board to own the transformation**, working with the **three places and the Cancer Alliance on local action plans**. Clinical leadership, engagement and participation, and patient representation are essential to the transformation work and so a **programme plan and engagement strategy will be developed**.

The immediate focus will be place-based, targeted redesigns for emerging priorities offering virtual clinics, patient-initiated pathways, and self-management and self-monitoring support.

7.2. Improving cancer outcomes

Our aim as a system is to improve early diagnosis rates, timely diagnosis and treatment, and to support our population to manage their own health and wellbeing through more personalised care, whilst ensuring that all care delivered is of the highest quality. Cancer is both a national and a local priority, which is why we are working towards national targets, as laid out in the NHS constitution and Surrey and Sussex Cancer Alliance (SSCA) plan, to be

delivered through local solutions across Sussex.[8]

7.2.1. Current state and challenges

The Sussex and East Surrey Cancer Board was constituted in July 2019 with the purpose of providing system-wide leadership and accountability for the delivery of transformational change across Sussex. The Board also oversees the delivery of plans and the achievement of the strategic objectives agreed by SSCA and STP Cancer Programme, and will play a key role in driving forward our strategy and achieving the ambitions of the Long Term Plan.

The Long Term Plan set out two bold ambitions for improving cancer outcomes which we are focused upon achieving:

- By 2028, 55,000 more people will survive cancer for five years or more each year
- By 2028, 75% of people will be diagnosed at stages 1 or 2.

The Sussex Health and Care Partnership has made recent progress against these metrics and other important indicators of cancer care, although there is still significant room for improvement:

- The proportion of cancers diagnosed at stage 1 or 2 has improved in Coastal West Sussex (CWS), Eastbourne, Hailsham & Seaford (EHS) and High Weald Lewes Havens (HWLH) with small reductions in other CCGs
- The one-year survival rate has improved across all CCGs comparing 2014 to 2016, with the largest improvement in Crawley CCG
- Patient rating of overall care has improved in all CCGs apart from Brighton & Hove and Crawley CCGs.

However, the ambitions are stretching, and we recognise that we face challenges in meeting them and in delivering the best possible care and outcomes for our whole population, as we are not currently consistently achieving national targets for two week waits or 62 day performance.

[8] See Surrey and Sussex Cancer Alliance, 'System Ambitions 2019-2024' for greater detail on all of our cancer programme areas. The Partnership is committed to working closely with SSCA to deliver on their five year system ambitions and specific programmes.

Early diagnosis – rolling one year average

Average of 1 Year Average (%)	2017 - Q3	2017 - Q4	2018 - Q1
England	52.1	51.9	51.8
NHS Brighton and Hove CCG	53.7	52.7	51.3
NHS Coastal West Sussex CCG	53.5	54.4	55.9
NHS Crawley CCG	52.8	50.5	52.1
NHS Eastbourne, Hailsham and Seaford CCG	49.5	51.1	51.9
NHS Hastings and Rother CCG	51.5	51.5	50.9
NHS High Weald Lewes Havens CCG	50.3	51.7	51.3
NHS Horsham and Mid Sussex CCG	48.9	48.3	48.4
Grand Total	**52**	**52**	**52**

Figure 36: Early diagnosis rolling one year average

One year survival

	Year of diagnosis		
	2014	**2015**	**2016**
England	71.5	72.2	72.8
NHS Brighton and Hove CCG	69.8	70.7	71.4
NHS Coastal West Sussex CCG	71.5	72.3	73
NHS Crawley CCG	70.4	70.6	72.1
NHS Eastbourne, Hailsham and Seaford CCG	70.6	71.1	71.8
NHS Hastings and Rother CCG	69.4	70.1	70.9
NHS High Weald Lewes Havens CCG	71.7	72.2	73.1
NHS Horsham and Mid Sussex CCG	73	73.8	74.5
Grand Total	**567.9**	**573**	**579.6**

Figure 37: One year survival rate

National Cancer Patient Experience Survey (CPES)[9]

The average rating given by respondents when asked to rate their care on a scale of 0 (very poor) and 10 (very good) is shown below.

	B&H	CWS	Craw.	EHS	H&R	HWLH	HMS
2018	8.6	8.9	8.7	8.9	8.8	8.7	8.7
2017	8.7	8.9	8.5	8.8	8.9	8.9	8.6
2016	8.7	8.7	8.8	8.7	8.7	8.6	8.6

Figure 38: NCPES results from 2016-2018

2 week wait[10]

	Seen within 14 days	Seen after 14 days	Total seen	Performance	Performance Target
2019-20	6,036	526	6,562	92.0%	93.0%

Figure 39: two week wait performance

31 day standard

	First Treatment within 31 days	First Treatment after 31 days	Total First Treatments	Performance	Performance Target
2019-20	899	29	928	96.9%	96.0%

Figure 40: 31 day performance

62 days urgent GP referral

	First Treatments within standard	First Treatments after standard	Total First treatments	Performance	Performance Target
2019-20	438	144	582	75.3%	85.0%

Figure 41: 62 days urgent GP referral performance

[9] www.ncpes.co.uk

[10] Two week wait, 31 day standard and 62 day standard data, www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times

62 days screening

	First Treatments within standard	First Treatments after standard	Total First treatments	Performance	Performance Target
2019-20	65	12	76	84.9%	90.0%

Figure 42: 62 days screening performance

With regards to screening and early diagnosis across Sussex, we perform worse than average in some areas and have significant variation between CCGs. Reducing this inequity of outcome is a key priority for our system as, across Sussex:[11]

- Bowel screening uptake ranges between 52.5% in Crawley and 63.0% in Horsham & Mid Sussex, against an English average of 57.3%
- Cervical screening uptake ranges between 68.2% in Brighton & Hove and 76.9% in Horsham & Mid Sussex, against an English average of 71.7%
- Breast screening uptake is furthest below the England average, as uptake ranges between 65.9% in Brighton & Hove and 72.2% in Coastal West Sussex, when the England average is 72.1%
- Sussex also performs lower than the national average for cancer staged (79.2% vs. 81.4%), and SSCA is the second lowest alliance in the country for cancer stages (2017 data)
- One-year survival ranges between 70.9% in Hastings & Rother and 74.5% in Horsham & Mid Sussex, compared to an English average of 72.8%.

7.2.2. Five-year vision and key delivery priorities

We share the vision of SSCA to develop and deliver world-class outcomes in cancer care and treatment for our population through greater integrated and personalised care over the next five years. We are working towards key national targets to:

- Significantly improve one year survival to achieve 75% by 2020 for all cancers combined
- Ensure that 95% of patients are given a definitive cancer diagnosis, or an all-clear, within 28 days of being referred by a GP, and 50% within 14 days.

To achieve our ambitious plans for future cancer care, we need to shift our focus towards reducing health inequalities through supporting our whole population to manage their health and wellbeing. Through online feedback and a series of workshops, SSCA has collaboratively agreed the top priorities for the Alliance which Sussex are committed to delivering.

[11] Data on screening rates, Fingertips, fingertips.phe.org.uk/profile/cancerservices/data

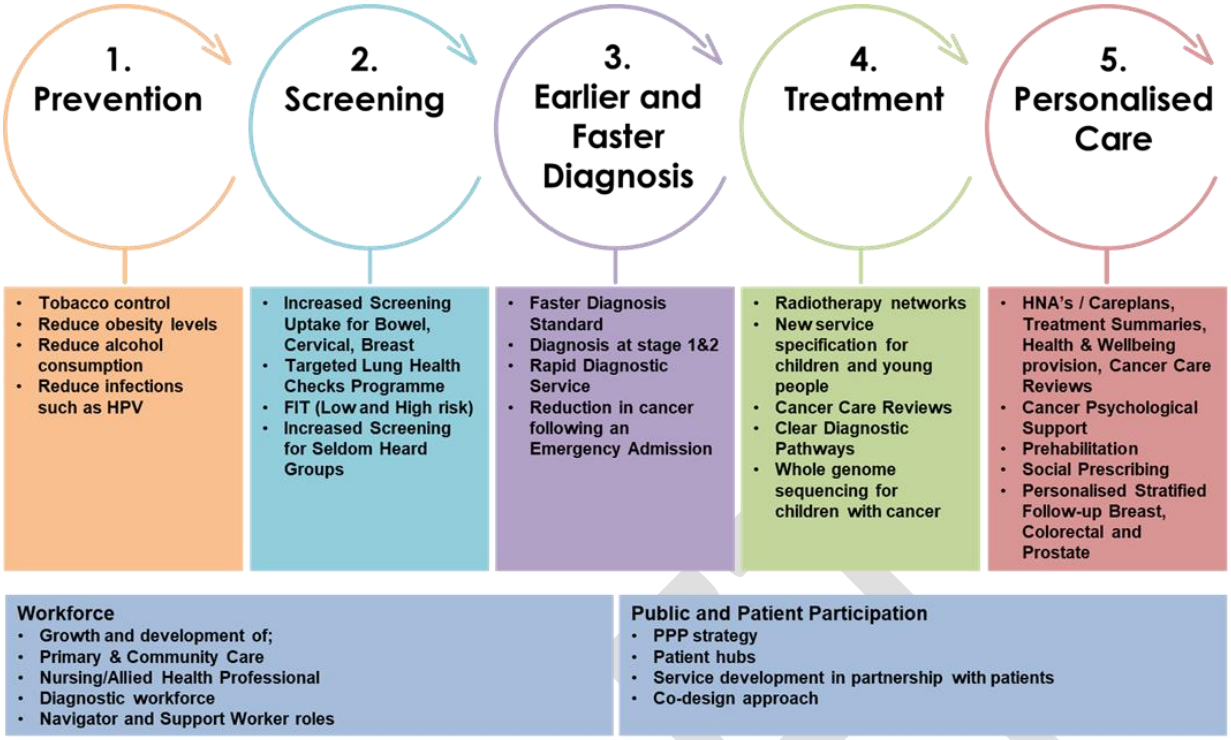


Figure 43: Key delivery priorities for cancer

7.2.3. Prevention

Our lifestyle choices affect our risk of developing cancer. Up to half of all cancer could be prevented by changes in lifestyle behaviours, so we recognise the need for a new approach to improve our public's health which will support cancer prevention efforts. If we are to tackle the health problems caused by smoking, poor diet, obesity, alcohol misuse and lack of exercise effectively, we need a whole system approach. Therefore, we will collaborate with the newly-formed Sussex Partnership Prevention Board and engage closely with the other Integrated Care Systems (ICSs) within SSCA to share learnings.

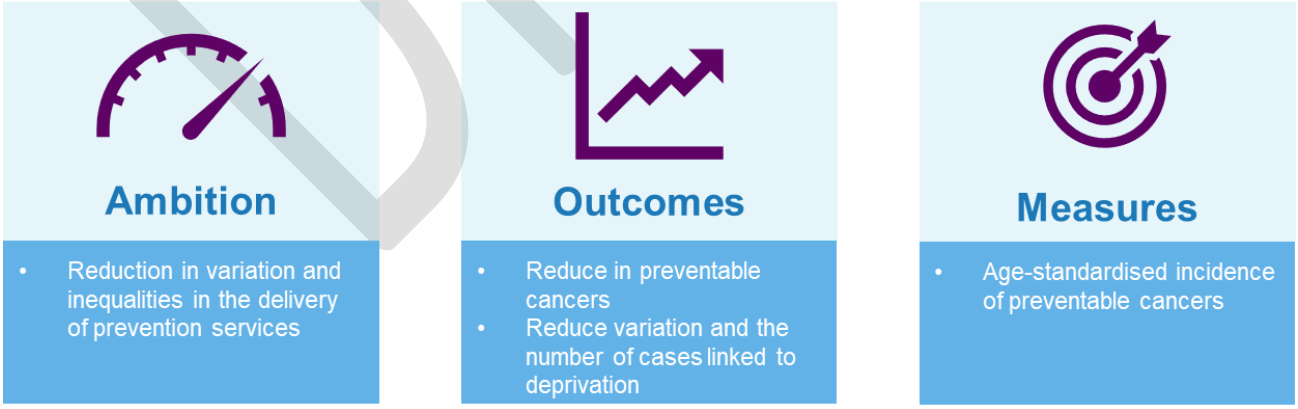


Figure 44: Our ambition, outcomes and measures to address preventable cancers

Closing the gap

Work is underway by the Partnership Cancer Early Intervention Project managers to review the inequalities across the region and to prioritise cohorts of patients where it is felt that the most impact can be achieved through interventions to increase screening uptake, linking to

deprivation and one year survival rates.

Making Every Contact Count

We support the system wide roll-out of 'Making Every Contact Count' (MECC) as a core training priority. The training provides the skills for any member of staff to confidently initiate a conversation about health behaviour change and to effectively signpost to supporting lifestyle services (via the MECC application which has been adopted by the local authority and wider Sussex Partnership). From 2020/21 the MECC approach will be used within the Rapid Diagnostic Services to encourage those patients who have not been diagnosed with cancer to participate in screening if eligible.

Raising awareness

SSCA will continue to support the national 'Be Clear on Cancer' programme and, within Sussex, we will raise awareness of cancer and prevention through:

- Community Ambassadors across Sussex.
- Public Health smoking cessation services. For more information, please see section 6 on Prevention and Appendix A.
- Drink Coach, a skype-based coaching service for those seeking to reduce their alcohol intake. Please see section 6 on Prevention for more detail and programme scoping.
- 'Active for Life' and equivalents in local authorities, commissioned activity such as 'Speak Up' provided by Albion in the Community in Brighton & Hove, 'One You' in East Sussex and other health/wellbeing coaching initiatives locally.
- Supporting the extension of the HPV vaccination programme to boys in school in year 8.

Over the past four years, the number of patients seen on a two week wait pathway has increased, and the data demonstrates that national campaigns have prompted some of this rise, but increases are also experienced outside of 'Be Clear on Cancer' campaigns which could be due to the lagged effect of campaigns or other factors.

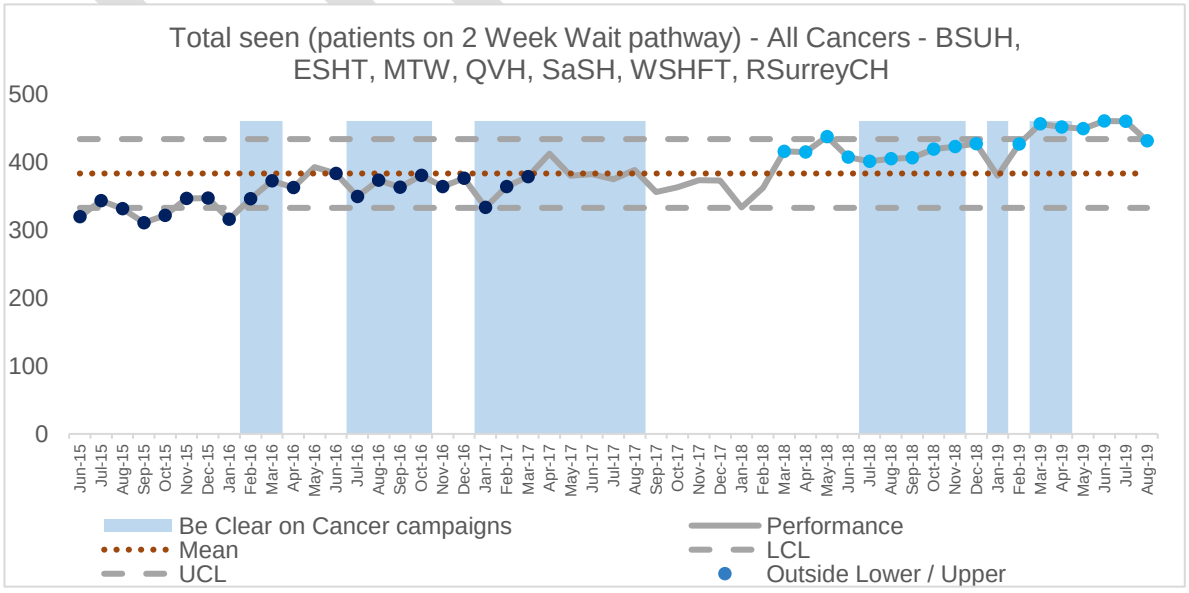


Figure 45: Patients on two week wait pathway

7.2.4. Screening

To achieve our ambition of increasing the proportion of cancers diagnosed at early stages, increasing the effectiveness and uptake of our range of screening programmes is vital.

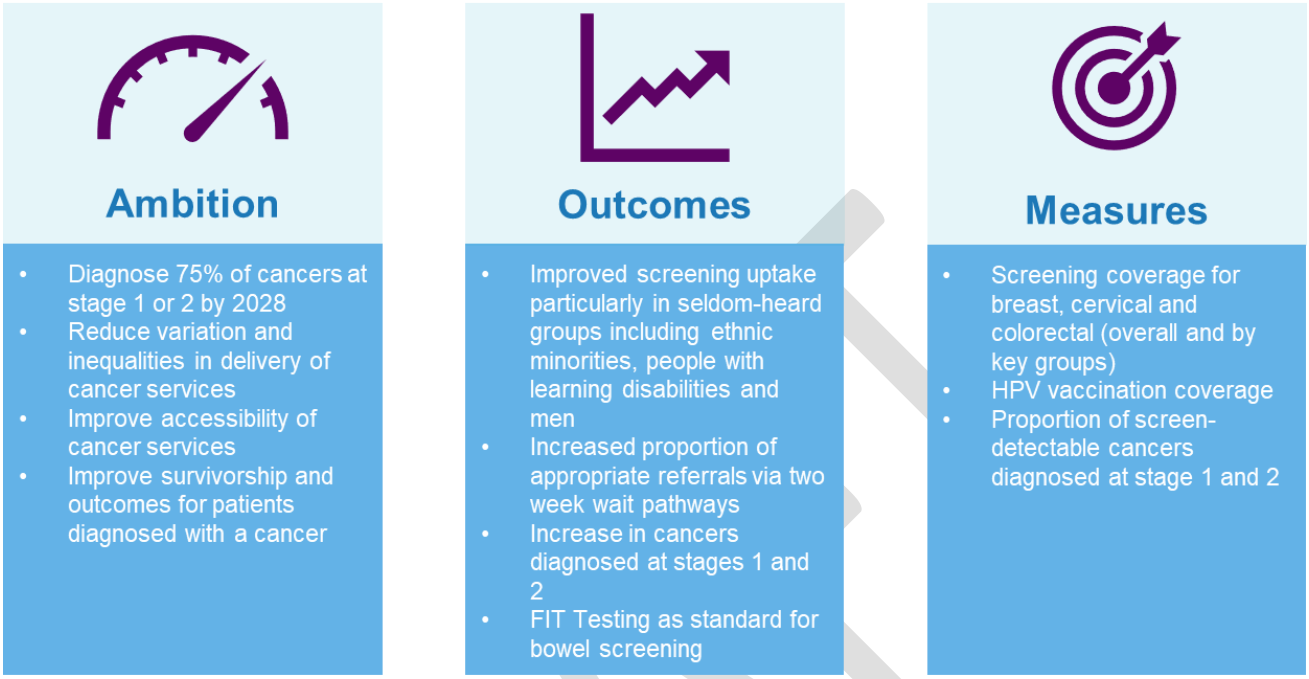


Figure 46: Our ambition, outcomes and measures to improve uptake of screening

Closing the gap

Targeted interventions

Local targeted interventions will be funded through Cancer Alliance transformation funding to improve performance across low uptake areas including Crawley, Horsham & Mid Sussex, and East Sussex. The interventions will be rolled out, evaluated, and any learning shared across the Alliance region to inform future targeted interventions over the next four years.

Alongside specific provider programmes to improve uptake of bowel, breast and cervical screening (please see Appendix A for more detail), we are raising public awareness of these programmes and working with partners such as Public Health to target inequalities for service users by supporting access for those with learning disabilities and the homeless.

Local Screening and Immunisation Leads will offer direct support on implementation, whilst NHSE will lead the development of public communications campaigns aimed at increasing uptake, particularly for underserved populations, and targeting inequalities. The joint screening forum led by Public Health England (PHE) and the Cancer Alliance will support sustainability of interventions by gathering and sharing intelligence to undertake a joint planning approach.

FIT

FIT testing commenced in early June 2019 and early evidence indicates an increased uptake compared to the previous **Guaiac** Fecal Occult Blood Test (gFOBT) method. PHE

will work to support our providers with capacity planning for the increases in activity expected as a result of the increased uptake and positivity about the new test, as well as the reduction of the starting age from 60 to 50.

Primary care

From April 2020, the Primary Care Network DES will put responsibility onto Primary Care Networks to improve earlier diagnosis, likely through an involvement in improving cancer screening uptake. Details of the exact specification of the DES are due in early 2020. We will continue to collaborate closely with our third sector partners, including Cancer Research UK (CRUK) who will continue to support Sussex practices by checking GP endorsement on bowel screening patient letters; showing bowel screening videos in practice waiting rooms; setting up practice alert systems for non-responders to enable opportunistic conversations on screening; contacting non-responders for screening; and engaging community groups in order to improve uptake.

SCCA and Sussex

Over the next five years, Sussex Partnership will work with SSCA to improve uptake and reduce variation across the region by:

- Developing a workforce initiative with HEE and local STPs/ICSs to ensure that the necessary workforce is both available and appropriately trained to deliver the programmes over the next five years
- Drawing from the national review to assess opportunities for the use of artificial intelligence and stratification in screening, and likely timescales and implementation approach
- Reviewing the findings of SSCA's evaluation of current local initiatives as well as national work undertaken to inform strategic planning on how best to maximise uptake of screening
- Integrating research and evaluation within screening on an ongoing basis
- Ensuring that the screening initiatives in the Alliance region support the wider efforts being made to promote early diagnosis of cancer
- Linking with other work programmes underway to ensure that approaches to increasing diagnostic capacity both for screening and symptomatic diagnosis of cancer are joined-up.

For specific actions being undertaken by CCGs and providers, please see Appendix A.

DRAFT

7.2.5. Earlier and faster diagnosis

Earlier diagnosis is critical to meeting our survival ambition, as it means patients can receive treatment when there is a better chance of achieving a complete cure. These improvements will come from a range of screening optimisation, targeted screening, better pathways, translation of research into treatment, and support for timely presentation by the public.

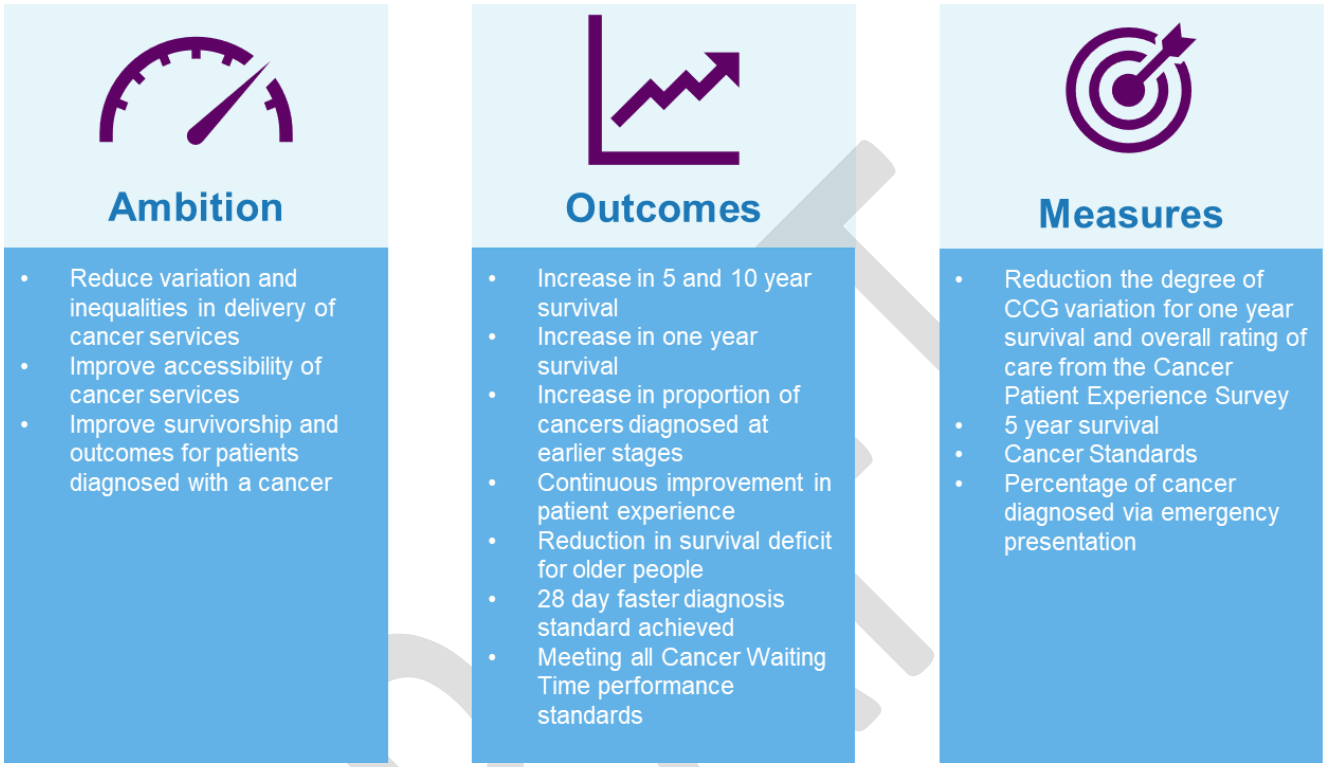


Figure 47: Our ambition, outcomes and measures to diagnose cancer earlier

Closing the gap

We are implementing the faster diagnosis standard and pathways across our whole Partnership to deliver quicker and safer care that reduces variation across Sussex. This is also the aim of the South of England Imaging Programme in the face of 12% year on year demand increases for services as well as ageing equipment. Through establishing an imaging network serving Surrey and Sussex, this will reduce variation across the service in order to drive efficiencies, expand capacity, enable equipment and estate investment, and deliver new ways of working in a sustainable service.

Rapid Diagnostic Services

The commitment to roll out Rapid Diagnostic Services (RDS) forms an important part of our broader strategy to deliver faster and earlier diagnosis, as measured by the new Faster Diagnosis Standard (FDS) from April 2020 and improved patient experience. Significant service changes, such as Rapid Diagnostic Services, will be vital in treating the number of people diagnosed with cancer which is expected to rise by 29% between 2016-2028. RDCs will also complement work to improve screening programmes, augment the potential of artificial intelligence (AI) and genomic testing, and utilise PCNs to improve early diagnosis in their localities.

By implementing RDSs, we aim to contribute to the following objectives:

- To support **earlier and faster cancer diagnosis** by assessing patients' symptoms holistically and providing a tailored pathway of clinically relevant diagnostic tests as quickly as possible, targeting and reducing any health inequalities that may currently exist
- To create increased capacity through **more efficient** diagnostic pathways by reducing unnecessary appointments and tests
- To deliver a **better, personalised diagnostic experience** for patients by providing a series of coordinated tests and a single point of contact
- To **reduce unwarranted variation** in referral for and access to relevant diagnostic tests, as well as in the tests' reliability, by setting standards for RDCs nationally, mandating consistent data collection to enable benchmarking, and providing regional support to roll out RDCs
- To **improve the offer to staff** with new roles which offer development opportunities, greater flexibility and a chance to work in innovative ways.

SSCA are aiming for a service provision rather than a fixed centre and are currently exploring virtual and face-to-face models which may differ in format between localities. The Alliance has completed a Capacity and Demand analysis of imaging modalities and endoscopy, and have used this data to inform our option appraisal for service delivery.

7.2.6. Treatment

Advancements in technology and clinical innovation mean that new and more effective treatment options are becoming available. We must ensure that, across Sussex, we maximise the impact of these opportunities to manage treatment of cancer to improve survival and quality of life outcomes.

DRAFT

Ambition

- Reduce variation and inequalities in the delivery of cancer services across Sussex
- Improve accessibility of cancer services
- Improve survivorship and outcomes for patients diagnosed with a cancer

Outcomes

- Equality of access to radiotherapy
- Replacement plans for radiotherapy equipment
- Increased participation of clinical trials
- Transfer to centralised genomics and molecular testing
- Diagnose and treat more patients at an earlier cancer stage
- Treatment options comply with national guidance
- Improved experience and quality of care
- All CWT performance standards met

Measures

- Increased % of cases needing surgical treatment
- Increased 1 year survival rate
- Increased utilisation rates of capacity
- Increased % patients diagnosed at stages 1 and 2

Figure 48: Our ambition, outcomes and measures to improve treatment of cancer

Two week wait performance varies across the Partnership, but variation is much more significant against the 62 day wait target where we perform below both the national and SSCA averages. It is, therefore, a key priority for Sussex to drive improvement against these standards including learning from high performing CCGs and within the Alliance.

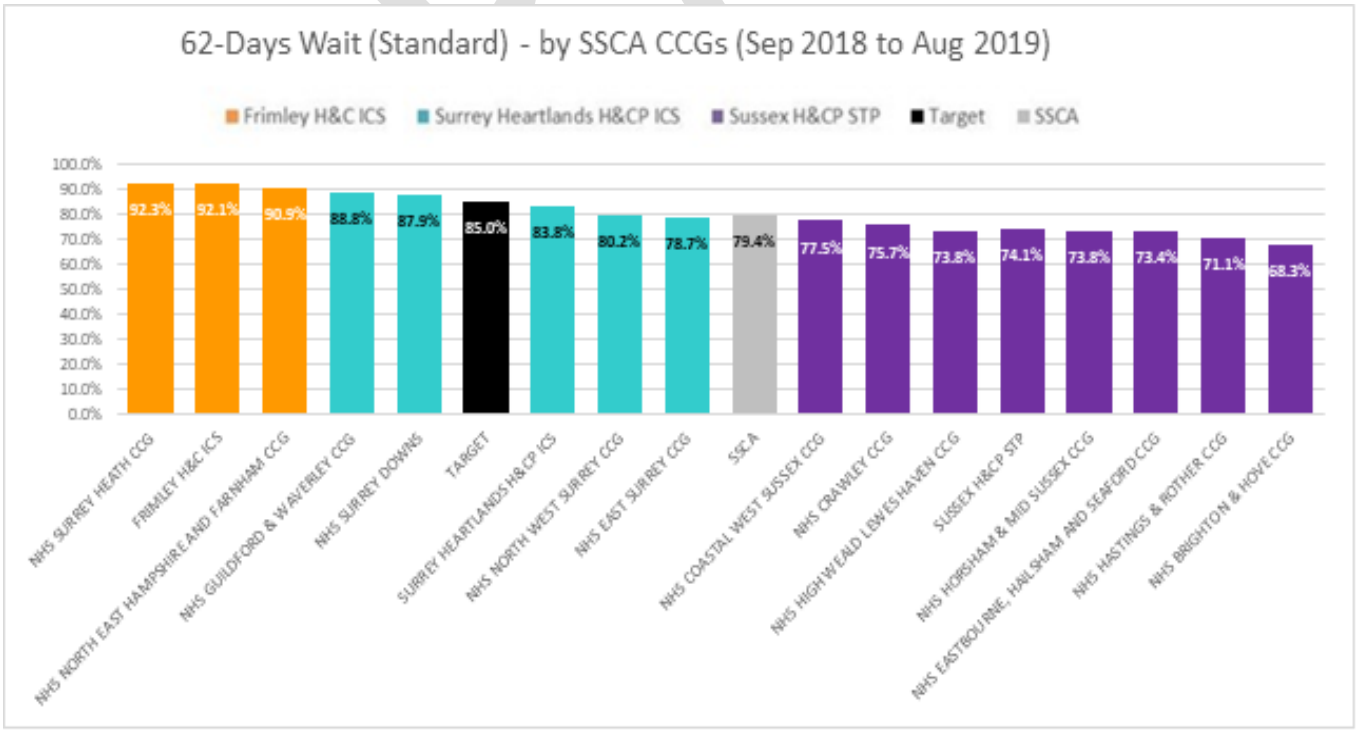


Figure 49: Performance against 62 day target

There are a range of factors which affect one year survival rates detailed below. For specific actions being taken by individual trusts and CCGs to address these factors, please see Appendix A and place-based plans in Appendices B, C and D.

Stage at diagnosis	Treatment with curative intent	Patient factors
Stage at diagnosis	Surgery	Co-morbidity and fitness
Patient delay	Radiotherapy	Age
Doctor delay	Chemotherapy	Health-related behaviours
System delay	Immunotherapy	Social and economic determinants
	Cancer drugs	
	Coordination of treatment	

Figure 50: Factors affecting one year survival rates

DRAFT

Recovery plans to achieve cancer waiting time targets

BSUH	• Individual tumour site recovery plans in place • Additional evening and weekend sessions in place in US/CT/MRI • Additional endoscopies • Lower GI and Upper GI are utilising any theatre capacity at short notice • Daily and Weekly escalation and patient level management enhanced • Ongoing exploration of virtual clinics and stratified pathways • Secured additional funding from SSCA for administrative support for performance improvement and for upper and lower GI triage nurses
ESHT	• New colorectal pathway incorporating FIT for high risk patients and STT (endoscopy) implemented February 2019. Colonoscopy reduced by 15%-20%. • Urology Investigation Suite opened in June, one stop service • Radiology capacity and demand gap analysis underway • Detailed capacity and demand review underway • Optimising capacity e.g. straight-to-test and telephone follow-ups • Secured additional funding from SSCA for FDS trackers, lung rapid diagnosis matron, upper GI triage nurse
MTW	• Action plans for each tumour pathway in development • Breast clinics to be re-mapped and additional capacity sourced • Increased imaging capacity sourced • Additional triage in secondary care so that patients with the highest suspected risks of cancer be transferred to alternative pathways • Daily huddles to identify patients that need to be expedited through the system for lower GI, upper GI, breast, urology, gynaecology, lung and haematology • Additional one stop clinic capacity for prostate, breast and lung pathways • Introduction of "straight-to-test pathways" for prostate, lung and breast • Test phase for the implementation of qFIT for low risk suspected colorectal cancer (Jan 2020)
WSHFT	• Action plans to implement 28 day FDS across all tumour sites (with an initial focus on 7 day first outpatient appointment) • Recruitment of 28 day FDS pathway trackers to enhance daily tracking and drive improvements in all tumour sites • Implementation of colorectal FIT 'low risk' (DG30) Oct 2019 and plans developing around FIT pilot in 'high risk' from Nov 2019 • Sustaining improvements in optimal pathways for colorectal and prostate ongoing • Implementing pathway improvements, Head & Neck one stop service and gynaecology fast-track pathway across hospital sites • Additional diagnostic capacity (radiology and histopathology) and reduced diagnostic reporting times • Renewed focus on lung ACE pathway

Radiotherapy and chemotherapy

RM Partners are hosting the nationally mandated Radiotherapy Operational Delivery Network (ODN) to deliver the national specification for Radiotherapy services published in January 2019. The ODN covers West London, Surrey and Sussex, and contains four radiotherapy centres (Imperial, Royal Marsden, Brighton and Sussex University Hospital and Royal Surrey Hospital). A work plan has been developed and agreed with NHS England and we will work with Specialist Commissioning to implement this.

Chemotherapy commissioning currently falls under specialist commissioning at a provider level and demand is expected to increase as we diagnose cancers more frequently and at earlier stages. SSCA have proposed a gap analysis to predict required workforce and physical estates space for delivery, including possible community based care.

Research and innovation

In order to meet national and local expectations regarding cancer research activity, we will

build upon existing relationships with research partners including the Academic Health Science Network, the National Institute of Health Research, and other partner organisations including the University of Surrey and the University of Sussex.

7.2.7. Personalised care

By 2030, it is estimated that there will be around four million people living with cancer across the UK. Support for our population living with and beyond cancer needs to be centred on the individual and delivered at the right time, in the right way. We are committed to supporting patients in personalised care planning across Sussex so that by 2021, where appropriate, every person diagnosed with cancer has access to personalised care including a full assessment of their needs, an individual care plan and information to support their wider health and wellbeing. This will link into and complement the social prescribing models being developed at place across Sussex.

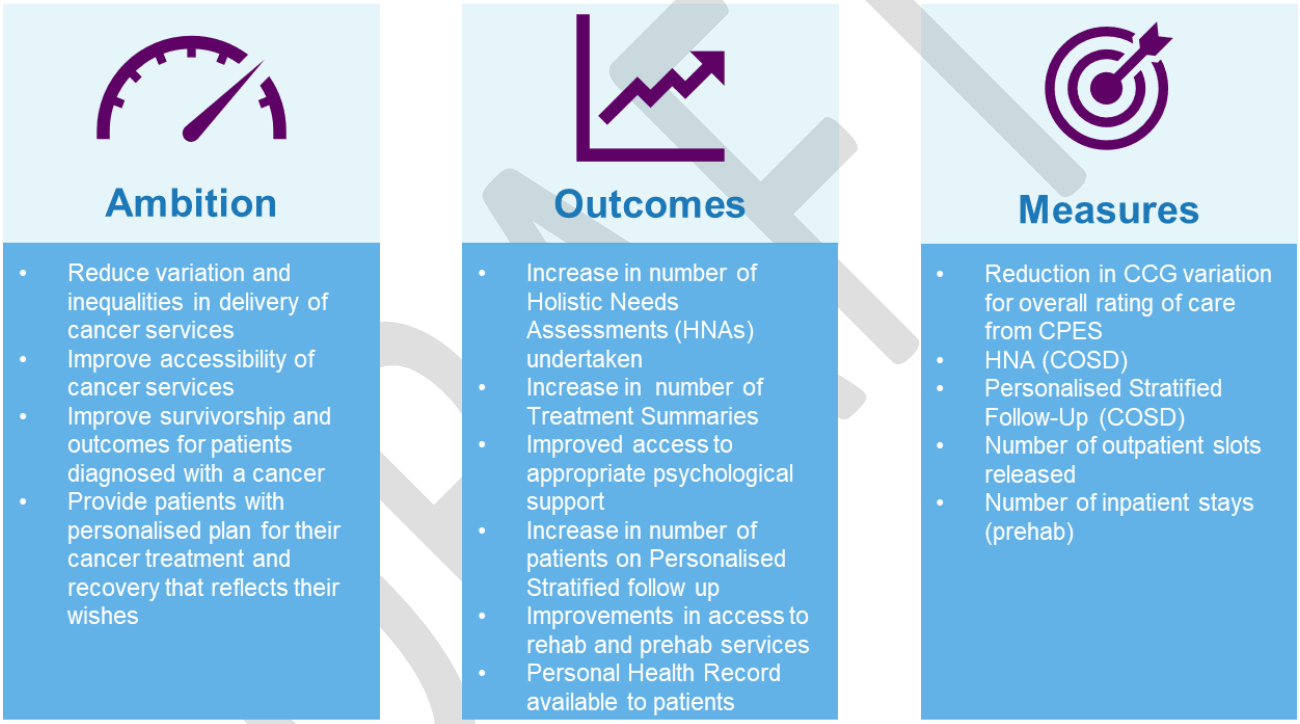


Figure 51: Ambition, outcomes and measures to improve personalised care

Closing the gap

Individual trusts have secured funding for new roles such as nurses and navigators to provide additional support to patients, and have initiated HNAs. For more detail on specific actions of trusts and providers please see Appendix A. We are implementing the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) programme to support cancer patients in making informed choices about where they want to die and to ensure that, as a system, we support them to do so.

Cancer coaches

SSCA is involved in an innovative project to develop a standardised framework for cancer coaches which will improve the quality and availability of support for our patients. We are

working on this with the University of Portsmouth, who are leading experts in cancer coaching, and the Fountain Centre, who host a significant number of cancer coaches each year. This will be funded in full by Health Education England and is a first step in improving access to psychological support for our patients, which will be continued through setting up a psychological support expert reference group to advise on future work. Please see SSCA's 'Proposal for Cancer Transformation Funding 2019/20' for more details on the project.

Digital support

SSCA has developed recommendations for future digital innovations to facilitate interventions such as holistic needs assessments and to enable greater personalisation. These include implementation of the Macmillan eHNA Tool, developments in the Somerset Cancer Registry, a remote monitoring solution and Personal Health Records.

Sussex Partnership have procured, and are implementing, the "Patient Knows Best" Personal Health Record solution into all providers, with ESHT identified as the initial pilot site. We aim to develop and implement an initial controlled pilot to support both colorectal and prostate cancer patients on supported self-management pathways by the end of 2019/20. This will be supported by a robust remote tracking system and will extend to breast pathways by 2021 as well as other tumour groups by 2023. These learnings will be collected and shared across SSCA to support the collective improvement of personalised care. Personalised care will also be promoted through the pathology hub at ESHT which will extend the use of molecular diagnostics.

SSCA

The Alliance works as an 'Observer Partner' in supporting the EU project 'Inter-Reg I-Know How' to help employees living with cancer remain at, or return to, work. Sussex has also been actively involved in the development and adoption of centralised guidance to support the implementation of personalised care interventions. We will work in collaboration with partners such as Macmillan to develop and test a model for prehabilitation services, and adopt Macmillan's 'Right By You' approach to deliver personalised, holistic support, integrated across multiple settings.

Specialist Commissioning will promote the expansion of Enhanced Supportive Care, to enable patient choice and informed decision making, pump-priming investment in priority cancer providers to achieve this, and taking a leadership role in sharing learning across the South East.

DRAFT

7.2.8. Workforce

To diagnose and treat cancer more effectively within Sussex will place a greater demand on diagnostic services, which requires a growth in the local cancer workforce as well as investment in new methods of delivering care to our population.

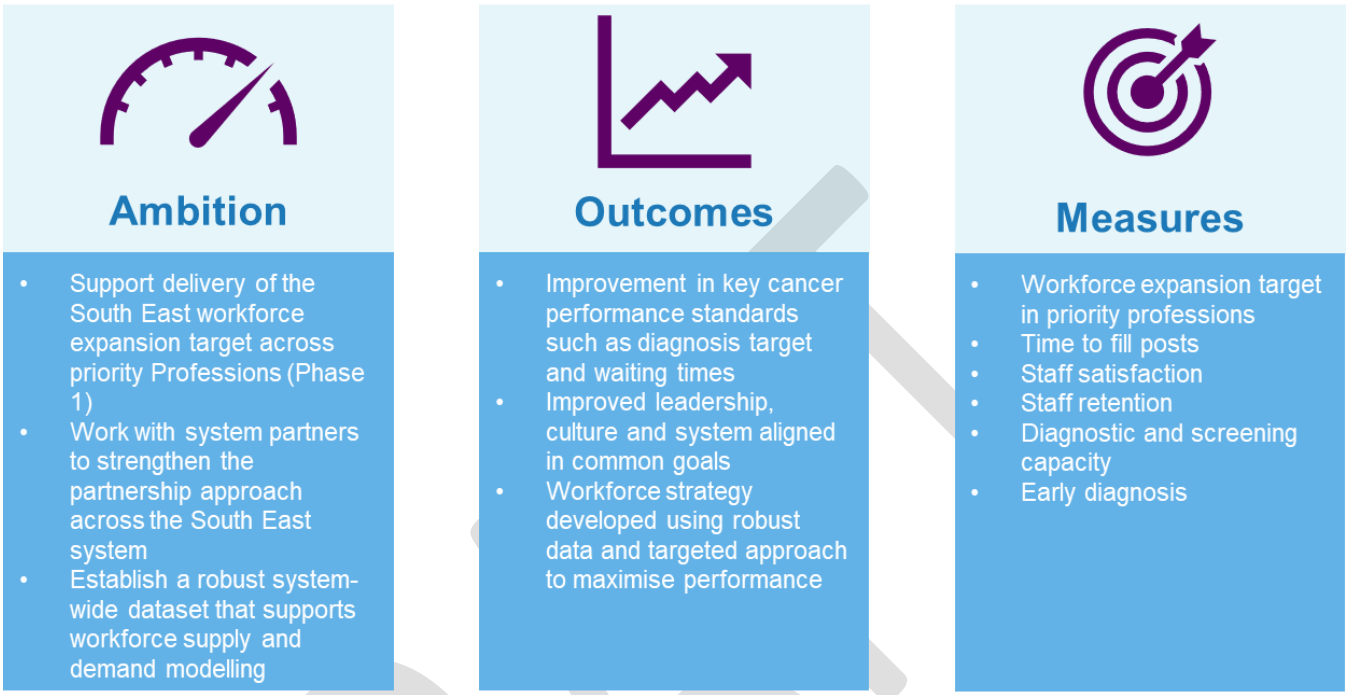


Figure 52: Ambition, outcomes and measures to improve cancer outcomes through a supported workforce

Closing the gap

The current activity of SSCA to ascertain the baseline workforce position and create specific action plans will be completed in partnership with Health Education England, and provide detailed targets for capacity and capability development to meet our demand trajectories. For more information on Alliance-wide actions with relation to radiographers, endoscopists, histopathologists, mammographers, CNSs, sonographers, screening and primary careworkforce, please see the Surrey and Sussex Cancer Alliance (SSCA) plan.[12]

Sussex are keen for SSCA to also consider oncologists, surgeons and theatre staff in their capacity assessment and to focus upon appropriate skill mixes across trusts. The workforce review will also need to take account of skill mix, role developments, rotation and flexible working across the Partnership, as well as cross-Alliance services such as the Operational Delivery Network and BSUH's position as a radiotherapy centre.

We acknowledge that the success of interventions aimed at improving early diagnosis will mean an increase in 'curative' treatments which, for some pathways, will mean an increase in the demand for surgeons, oncologists, radiotherapists and other staff.

[12] See Surrey and Sussex Cancer Alliance, 'System Ambitions 2019-2024', pg 41

7.2.9. Public and Patient Participation

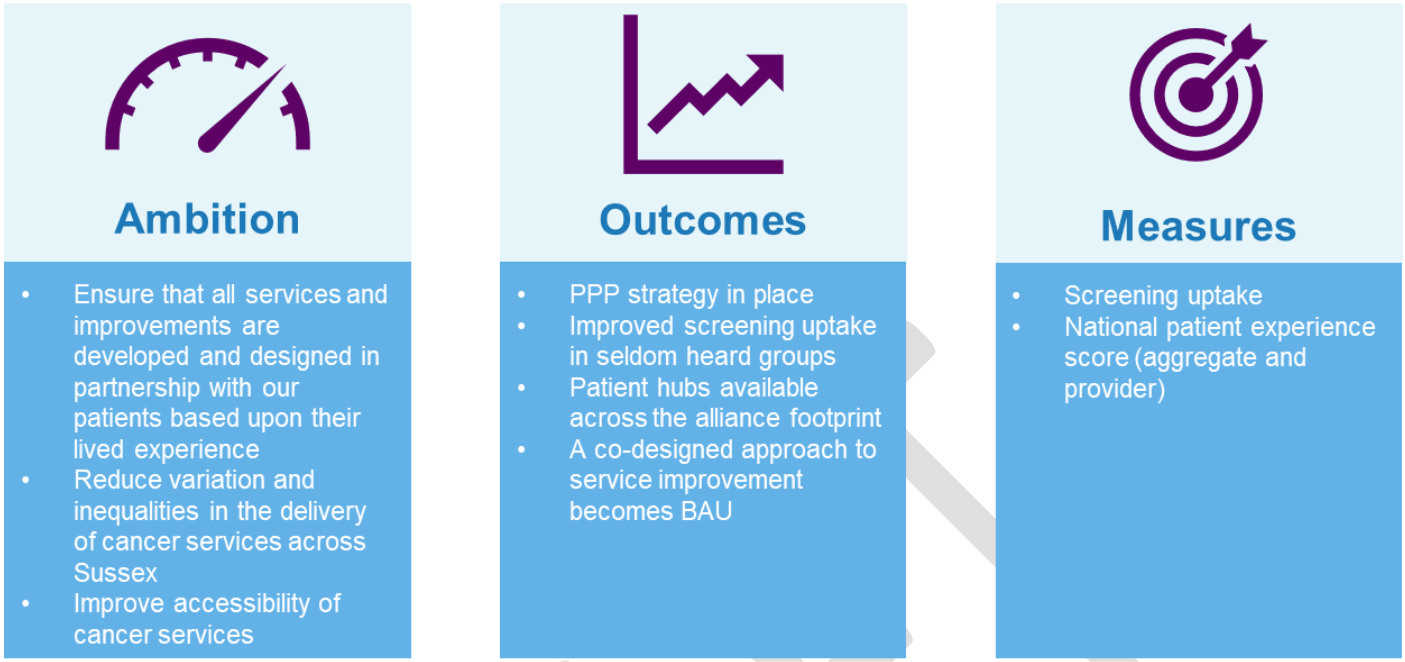


Figure 53: Ambition, outcomes and measures to improve public and patient participation

Feedback

The Partnership has undertaken significant patient engagement which drives both the priorities within this plan and the phasing of those priorities. The 2018 Cancer Patient Experience Survey (CPES) scores demonstrated that patients were overall very satisfied with the quality of their care, with ratings between 8.6 and 8.9 out of 10 across all trusts.[13] Areas for improvement were also identified and have contributed to the strategy in the following ways:

- Across three trusts, scores in 2016 were lower than average for support given to patients during treatment by general practice. Therefore, we are running ongoing GP education and ensuring that each patient has an individual care plan which is circulated within primary care.
- In two trusts in 2016, there was room for improvement around Clinical Nurse Specialist (CNS) provision and support, so we are working in collaboration with system partners to ensure that all patients have access to the right expertise through CNS and support workers.
- In 2018, scores were lower than average for length of time spent waiting for a diagnostic test in two trusts, which will be addressed by the introduction of Rapid Diagnostic Services.
- The proportion of patients with whom taking part in cancer research was discussed was also lower than average in two trusts, which highlights the need to further promote rapid uptake and spread of innovation.

[13] The 2018 results were only published in September 2019, therefore the previously available 2016 results have contributed to the current strategy and the 2018 results will be used on an ongoing basis.

Communication approach

Screening is one of the key areas of the SSCA strategy that can be locally supported by effective and coordinated communications across Sussex to raise awareness and improve accessibility of screening for bowel, breast and cervical cancers.

Communications activities will be targeted using insights, based on evidence of screening uptake and supporting national campaigns to support improvements and build upon our successes. Tailored communications will be data-driven and targeted to sections of the community who are not taking up their screening opportunities, and to GP surgeries where patients have a low take-up.

All CCGs have taken, and will continue to take, an active part in all the national campaigns:

- **March -** Cervical Screening campaign
- **April -** Bowel Cancer Awareness Month
- **June -** Cervical Screening Awareness Week (Jo's Trust campaign)
- **July -** Be Clear on Cancer campaign
- **October -** Breast Cancer Awareness Month

CCGs will continue to work with local community and voluntary sector groups as well as linking in to events to promote awareness and support people living with cancer. For example:

- Brighton and Hove Albion's community project helps cancer patients get back to fitness and was featured on BBC Match of the Day in 2018
- Switchboard, together with Macmillan, hosted a creative focus group consulting about LGBTQ cancer care to support people living with cancer on the 15th October 2019 for healthcare workers and volunteers

Leaflets and posters	Designed materials will be sourced with relevant messages and disseminated, and made available in a wide range of targeted public locations, this will include within GP surgeries
Media	The media plays a key role in influencing people's opinions and knowledge and, as such, we will utilise this to promote the screening programmes
Website and social media	Cancer screening information will have a presence on CCG websites, and the screening messages will be promoted heavily through CCG social media channels
Existing CCG communications	The screening messages will be promoted through the CCGs' existing communications to staff, members and the public, including the weekly staff and GP practice bulletins and external newsletters
Partners, stakeholders and local employers	The CCG will provide communications materials for partners, stakeholders and local employers to promote the screening messages
Events/groups	We will engage with key audiences at established groups and planned events - meetings, forums and groups - to discuss the key messages and gather feedback from those present
Digital communications channels	We will undertake a number of communications initiatives through digital channels throughout the campaign

Figure 54: Communication materials and channels

Accessibility

Sussex Partnership is fully committed to ensuring that our communication methods are accessible to all members of the community, and will proactively take steps to ensure the

core messages relating to cancer are promoted in accessible formats, including British Sign Language and Easy Read format. We will also inform organisations who can provide support for vulnerable patients. These will include:

- Sussex Interpreting Service
- Speak Out (for adults with learning disabilities)
- Carers Centre
- LGBT Switchboard
- Age UK

For more detail on metrics, priorities and cancer planning, please see the Surrey and Sussex Cancer Alliance Long Term Plans for 2019-2024.

DRAFT

7.3. Improving mental health outcomes

7.3.1. Current state and challenges

In 2017, what was previously the Sussex and East Surrey STP developed its case for change which laid out how the health and care system in Sussex could better help people with mental health conditions to lead more fulfilled lives. We knew that:

- Severe mental illness affected 25,000 individuals in Sussex, with many more affected by common mental health problems including anxiety and depression
- Local mental health services were stretched and demand on services was increasing significantly year on year
- Crisis care provision for people with mental health problems in Sussex was failing to meet people's needs
- Individuals with severe mental illness in Sussex died between 15 and 20 years younger than those without
- Dementia prevalence was 25% higher than nationally reported figures
- Three quarters of first episodes of mental ill-health occurred in young people and yet mental health services for children and young people were under particular demand pressures
- We would not solve the problems facing mental health services unless we undertook a programme of major transformational change.

Our current mental health transformation plans have been developed through extensive public engagement with service users, carers, partner agencies, providers and commissioners. They began with the Sussex Partnership NHS Foundation Trust Clinical Strategy (March 2017), which was built upon through an independent review of mental health provision resulting in the STP Mental Health Case for Change (November 2017), and then further developed and refined to produce the STP mental health transformation programme. More recently, we have incorporated the priorities of the Long Term Plan into our local transformation programme which has resulted in the development of the following workstreams:

- Perinatal Mental Health
- Children and Young People (CYP) Mental Health – including CYP Crisis
- Adult Common Mental Illnesses (IAPT)
- Adult Severe Mental Illnesses (SMI) Community Care
- Adult Liaison Mental Health
- Adult Crisis Alternatives
- Ambulance mental health provision (all ages)
- Therapeutic Acute Mental Health Inpatient Care
- Suicide Reduction and Bereavement Support
- Rough Sleeping Mental Health Support

Within Sussex, we are well placed to deliver upon all of these ambitions for mental health as a result of having:

- An agreed integrated strategic approach to mental health transformation for Sussex that has been developed through robust partnership work between commissioners, local mental health providers and local service users, carers and their families. These

strategic plans are fully aligned with the LTP priorities for mental health.

- An agreed delivery approach within the Partnership that enables us to successfully manage major mental health transformation work through strong integrated partnership arrangements between commissioners and providers.
- A well-established leadership and governance framework for mental health across the Sussex Partnership which has been in place since early 2018, led by the Partnership's Mental Health Programme Board and supported by a Mental Health Delivery Group and Finance Group.
- Identified mental health as a priority area for our Partnership which is enabling us to challenge systems and processes across physical, social and mental health settings and more effectively address the physical / mental health integration agenda.
- Good strategic partnerships in place across sectors and systems with clear plans to develop these further, for example through the development of a joint mental health/prevention strategy in 2020/21.

7.3.2. Five-year vision

By 2025, all people with mental health problems in Sussex will have access to high quality, evidenced-based care and treatment delivered by integrated statutory, local authority and third sector services that are accessible and well connected with the wider community, and that intervene as early as possible in someone's life journey to prevent mental ill health.

Our mission

We will work together as an Integrated Care System, bringing together patient, statutory, third sector and local authority expertise, to design, develop, commission and oversee high quality, innovative and integrated care and treatment pathways for people with mental health problems. We have also set clear trajectories to meet the seven key activity metrics for mental health relating to Out of Area Placements, SMI health checks, perinatal mental health, meeting the Core 24 standard, EIP services, and 24/7 crisis provision. For more information, please see activity modelling in the Strategic Planning Tool in addition to the greater detail provided in Appendix E.

Our road map

We have described our detailed plans for the future of mental health services in Sussex in the attached commitments planner, Appendix E. This lays out our current state, five year objectives, actions to meet these objectives, key performance indicators, and interdependencies for each of our workstreams. These plans will be delivered in line with our roadmap for Sussex which lays out objectives and current progress.

DRAFT

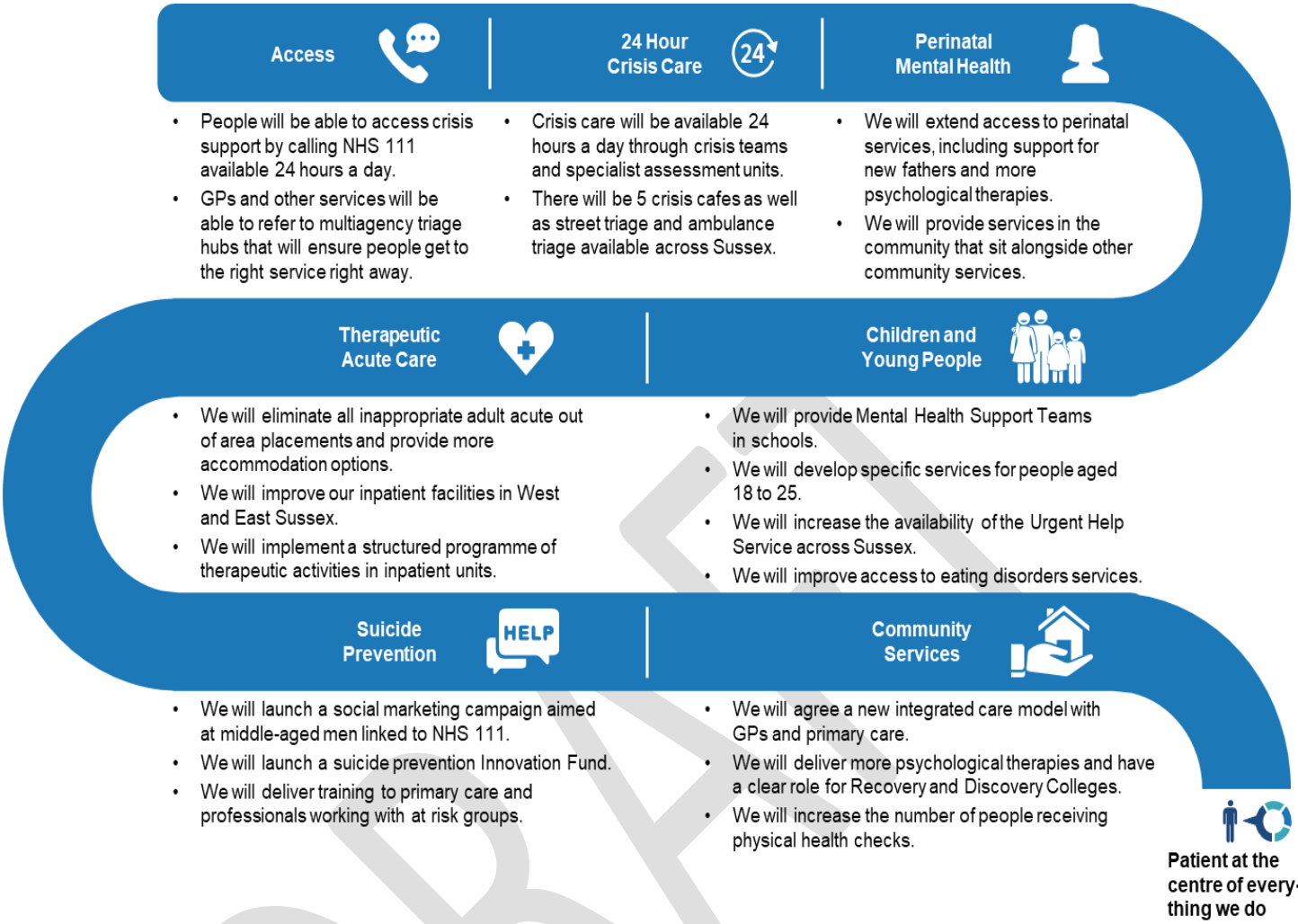


Figure 55: Our mental health delivery roadmap

7.3.3. Key priorities to deliver

- **Clear and detailed transformation plans for mental health services that are owned by the whole healthcare system**. We believe we already have these in place (detailed in the above section).
- **Robust leadership and governance that adapts to the changing healthcare environment**

Our current leadership and governance structures are overseen by two executive sponsors, the CEO of our Provider Trust and the Deputy CEO of our seven clinical commissioning groups, who chair the Partnership Mental Health Programme Board. A broad range of stakeholders from across our system sit on our Programme Board and it meets quarterly to assure the delivery of our priorities and the identification and mitigation of key risks. Our delivery and governance structures are supported by our Delivery Group (chaired jointly by our two SROs) and Mental Health Finance Group (chaired jointly by our provider FD and Commissioner FD). Robust governance and risk management systems are in place.

Moving forwards, we will need to further develop these governance and leadership structures to reflect the needs of the Sussex Integrated Care System (ICS) – and the requirements and reporting arrangements of CCGs, PCNs, provider trusts, and the third sector, that make up the ICS.

1. *Financial planning*

We welcome the Long Term Plan (LTP) commitment to grow investment in mental health services faster than the overall NHS budget. Our financial plan for mental health assumes an increase of £50.5m over the next five years, plus an estimate of fair shares additional funding of £18.8m. Further transformational funding has not been included at this stage.

In terms of financial governance, we already have a well-established Mental Health Finance Group in place that is jointly chaired by our provider and commissioner Finance Directors. This group will ensure that there is full oversight of the investment in mental health and that the investment is used to support the delivery of the commitments in the Five Year Forward View for Mental Health and the Long Term Plan.

2. *High quality workforce plans*

We are committed to delivering our transformation plans at pace and scale. Yet, despite timely, detailed and high quality business plans for our workstreams, the key underlying risk to delivery is the availability of our workforce. We must balance the staffing requirements for new services and new roles with the need to avoid overly disrupting operational activity within existing services. To mitigate this risk, we have set up a dedicated workforce group, chaired by senior provider and commissioner leads with input from the Sussex Partnership Workforce Director and HEE mental health lead.

We have undertaken detailed workforce modelling for 2019/20 to help forecast workforce and recruitment pressures across our workstreams. We have also secured additional funding for HR and recruitment support and implemented several new roles into the mental health workforce, including peer workers, graduate mental health workers, non-medical prescribers, nursing associates, physician associates and non-medical Responsible Clinicians.

In anticipation of the need to recruit significant numbers of new staff, work is under way to develop an overarching workforce plan that identifies potential recruitment streams. As part of this, the trust has been actively developing a range of new roles, including Nurse Associates, Peer Support Workers, Graduate Mental Health Practitioners and Physician Associates, in recognition that the level of workforce expansion will only be achieved through thinking more broadly about the range of skills and experience needed to deliver services in the future.

3. *Partnerships and place*

Whilst we have strong principles around partnership working already embedded in the programme, we are ambitious with our plans to further develop and strengthen the role of housing and third sector partners. We have developed a task and finish group (Sector Connector) to support a diverse sector to influence change and engage more fully in the work of our mental health programme. Proposals are being developed for sector representation on the Programme Board, the development of mental health forums for the three places, and an overarching mental health Partnership Board across Sussex.

We are fortunate to have some well-established third sector partners providing a range of

services across Sussex, for example, Southdown Housing Association provides social prescribing services across East Sussex, working closely with Primary Care Networks. The West Sussex Pathfinder Service hosted by Worthing Mind also offers:

- Access to a clinical service provided by nurses and occupational therapists from Sussex Partnership NHS Foundation Trust who work alongside other Pathfinder agencies
- Support to successfully discharge people from Sussex Partnership teams (Step Down) and to link them to the wider Pathfinder Alliance
- Proactive preventative support and links to Sussex Partnership teams if required (Step Up) for people accessing Pathfinder Services
- Improved links for people between other critical partners (Step Across), such as 'Time to Talk'.

Developing partnerships at place level across health and social care is critical to the success of this transformational programme of work. Embedding the mental health priorities within mainstream health and social care provision is key to delivering improved outcomes for people within our communities who need mental health support. Workstreams such as Community, IAPTS, Dementia and Suicide Prevention have a strong place-based focus and more information can be found on our programmes of work and the role of the places within Appendices A,B,C and D. As part of our programme review, we are working through our governance and programme function and structure to strengthen support to places and PCNs and to articulate clearly the role of Sussex Health and Care in supporting the delivery of the plans.

Considering the different population and demographic needs across our diverse Partnership is necessary to enable specific local needs to be addressed, whether this is supporting rough sleepers in Brighton & Hove, addressing the mental health needs of an ageing community in East Sussex where 26% of the population is over 65, or supporting the reduction in hospital admissions for self-harm in young people in West Sussex. We are committed to using our data to develop local solutions to specific local need and tailoring our Sussex-wide policies for maximum impact.

4. Consolidating capacity and capability

Through our transformation workstream plans, we are ensuring that we have access to dedicated finance and data analytics support to strengthen our ability to demonstrate Quality Improvement across the programme in reducing cost, improving health outcomes, and improving our service user experience.

Additionally, we have established a Data and Analytics Task and Finish Group to develop further recommendations for our Programme Board. Our portfolio of work also includes ambitious use of digital technology, and intrinsic to this is Sussex Partnership Digital Exemplar status. Robust estates plans will also be key to the successful transformation of our community, patient flow and rehabilitation workstreams, including the development of more supported housing for our service users.

5. Prevention

Across Sussex, we are committed to developing a prevention strategy for mental health. The approach will build upon the SPFT prevention strategy and the broad range of prevention work that is already in place across Sussex. The mental health prevention strategy is being

co-produced with public health colleagues and will be reflective of the broader Partnership prevention strategy, drawing strong links between mental and physical health. By working closely with the Prevention Board and our public health colleagues, we are highlighting the importance of place-based working, and developing local plans that are based upon the needs of the local population. For more information on mental health prevention please see Appendix A and section 6 on Prevention.

6. Provider Collaboratives

Locally, we have worked with Specialised Commissioning to engage with the national Provider Collaborative process which has sought to devolve specialist budgets to local providers. This has been through a shadow New Care Models phase since 2017 with adult secure services in Kent, Surrey and Sussex, and with CAMHS services in 'Wessex' (Hampshire, Portsmouth, Southampton, Isle of Wight and Dorset).

This has proved a successful service model and development process which has brought together a wide range of partner organisations, designed new care pathways, introduced efficient mechanisms, and controlled expenditure for specialist placements. This has been achieved by focusing on the needs of the individuals receiving services through developing intensive community services and bringing people nearer to their homes.

Together with Specialist Commissioning, we will:

- Ensure that Case Managers are in place to manage the Long Term Segregation and Seclusion quality improvements
- Reinvest savings from Adult Secure Services NCM pilots into Forensic Outreach Liaison Services
- Take commissioning responsibility for patients requiring Adult Secure Care, CAMHS Tier 4 and Adult Eating Disorder Services
- Align the ambitions of the CAMHS Tier 4 Bed Capacity Plan and support delivery of the South East share of the National Accelerated Bed Plan with local ICS/STP MH plans for children and young people.

The Sussex Partnership now has agreement in principle, pending submission of final business cases, to be the Lead Provider for the Provider Collaboratives across the STP for Adult Secure Services, CAMHS Tier 4, and adult eating disorders. The development process will fit with the three national streams of work and be banded as follows:

- Kent, Surrey and Sussex Adult Secures and Wessex CAMHS: "Fast track" – with approval planned for December 2019 and contracts signed for a 1 April 2020 commencement
- Sussex and Surrey CAMHS: "Development" – with approval planned for 2020 and commencement on 1 October 2020
- Adult Eating Disorders for Sussex and Kent: "Further development" – a longer timeline fitting in with further calls for applications in April 2020.

The total value of the contracts when fully operational in 2021/22 will be £150m per annum. This budget will form the lead provider commissioning budget for services across Kent, Surrey and Sussex for Forensic and Eating Disorder services, and for CAMHS in patient services across Sussex, Kent, Hampshire, Southampton, Portsmouth, the Isle of Wight and Dorset. The table below indicates the split of this between specialties:

	No. inpatients	Budget (£'000s)	Infrastructure (£'000s)	Total (£'000s)
Total Forensic Services to transfer from NHSE	408	92,093	600	92,693
Total CAMHS services to transfer from NHSE	208	46,119	500	46,619
KSS Eating Disorders			1,218	1,218
Infrastructure costs transfer estimate	30	10,038	-	10,038
Total	646	148,250	2,318	150,568

Figure 56: Specialty split for provider collaboratives

7.3.4. Public engagement

In developing the case for change which underpins our current mental health transformation programme, we held two large scale workshops with service users, NHS and local authority professionals, health and care commissioners, and providers. We interviewed 60 system leaders, GPs and representatives of service users. We also surveyed over 400 service users and carers using an online survey and sought views from clinicians and the voluntary sector. In addition, we analysed data provided by local authorities, commissioners and providers of mental health services, and others.

Service user involvement related to mental health within Sussex has been, and continues to be, comprehensive. There is a patient lead who attends the Delivery and Programme Boards and co-chairs the Expert Reference Group, also attended by the CEO of Healthwatch. Our role is to work together to ensure that the groups are continuously thinking about the patient perspective, representing information gathered through the workstreams, and engaging at different levels.

The workstreams develop engagement events across Sussex to provide feedback and collaboration opportunities for patient and carer input into finalising and agreeing papers and documents. The Expert Reference Group provides a pragmatic view of information coming from NHSE and ensures that the groups are considering local issues alongside national requests. Their role is to influence the volume of engagement that workstreams have with public, patients and carers at a Sussex-wide and place level.

7.3.5. Digital and estates interdependencies

The Mental Health Programme requires digital solutions and innovations to help us achieve the ambitions set out in our plans. We are fortunate that Sussex Partnership Trust (SPFT), our main mental health provider, is a digital exemplar site. For all our workstreams, the use of digital solutions to provide remote consultations, Apps to provide a proactive, self-care approach, and the roll-out and adoption of online platforms, have been identified as important. Capturing and sharing data is a priority and, with the expectation that we will work with a wide and diverse range of providers, we must ensure that data can be captured and information shared across sectors and settings. The cost of our digital transformation

programme will be substantial, not least due to the cost of equipment and telephones for a significant increase in workforce.

The estates requirements to enable us to deliver the Long Term Plan are substantial. With an increase of over 600 staff over a five year period, new models for providing work spaces and hubs for staff will be a priority. More joined-up working will lead to teams being co-located. We have some stretching targets for remodelling community support and providing crisis support for the people of Sussex, and this will require new facilities with crisis cafes being embedded and located within local communities.

We will need significant investment in the community estate to support both increased staffing and closer integrated working with all STP partners. This will include hubs for specialist MH teams that can accommodate the staffing increase and support joint working across teams and organisations. We also need space in primary care services to deliver clinical services and allow for joint working. For more information on the Sussex estates priorities, please see the estates section, 9.2.

We have also identified the need for capital investment of around £70m for mental health inpatient services in East Sussex to ensure that they are fit for purpose and able to flex to future service developments. This will enable us to eliminate mixed sex accommodation, remove dormitories, and increase therapeutic activity with the aim of reducing length of stay.

DRAFT

7.4. Delivering further progress on care quality and outcomes

7.4.1. Maternity and neonatal services

Governance and context

The Sussex Local Maternity System (LMS) formally comes into being on 1st April 2020, developing from the Sussex and East Surrey LMS in response to the changes in STP Boundaries agreed in 2019.

The LMS is transforming local services to achieve the Better Births and Long Term Plan recommendations for maternity services in a way that meets our population's needs, reduces gaps in health inequalities, and improves outcomes.

We are a partnership of local organisations:

- 3 Sussex trusts (ESHT, BSUH and WSHFT) who deliver maternity services
- 1 Surrey trust (Surrey and Sussex) and 1 Kent trust (Maidstone and Tunbridge Wells) who deliver maternity services to Sussex residents from buildings in Sussex
- 3 local authorities including Public Health
- 7 Clinical Commissioning Groups
- 5 Maternity Voices Partnerships (East Sussex, Brighton & Hove, Mid Sussex, SaSH and Western Sussex) representing service users and supporting co-design
- Clinical Networks including the Neonatal Network and the Perinatal Mental Health Networks
- 2 NHS trusts who provide the Healthy Child Services in Sussex

Sussex has a fully approved plan for maternity transformation, developed through significant engagement, which is fully endorsed by the Sussex Health and Care Partnership, the CCG Governing Bodies, and NHS trusts. The LMS Plan describes how we will meet our population's physical, mental and psycho-social needs from maternity services, and the opportunities that exist for us to improve maternity service safety, outcomes and personalisation.

Vision

The vision for maternity services in Sussex, as set out in the LMS Plan, to be safer, kinder, more personalised with real choice has been strengthened with the publication of the Long Term Plan (LTP). The LTP asks Local Maternity Systems to extend the scope of their improvements with a particular focus on addressing health inequalities, improving the post-natal pathway, supporting neonatal service improvements and extending the support available to those with perinatal mental health needs, recognising that the impact can last longer than one year after birth.

We will deliver these changes through close partnership working and integration of services around service users. We will recognise people's differences and accommodate these, as far as is possible, to deliver safer, kinder and more personalised maternity care.

Broadly, whilst the overall birth rate in Sussex is not predicted to change, we recognise there is change more locally within some areas in Sussex. By successfully delivering the LMS Plan we will, as a Health and Care Partnership, achieve better value for the £109 million we

spend each year on maternity services.

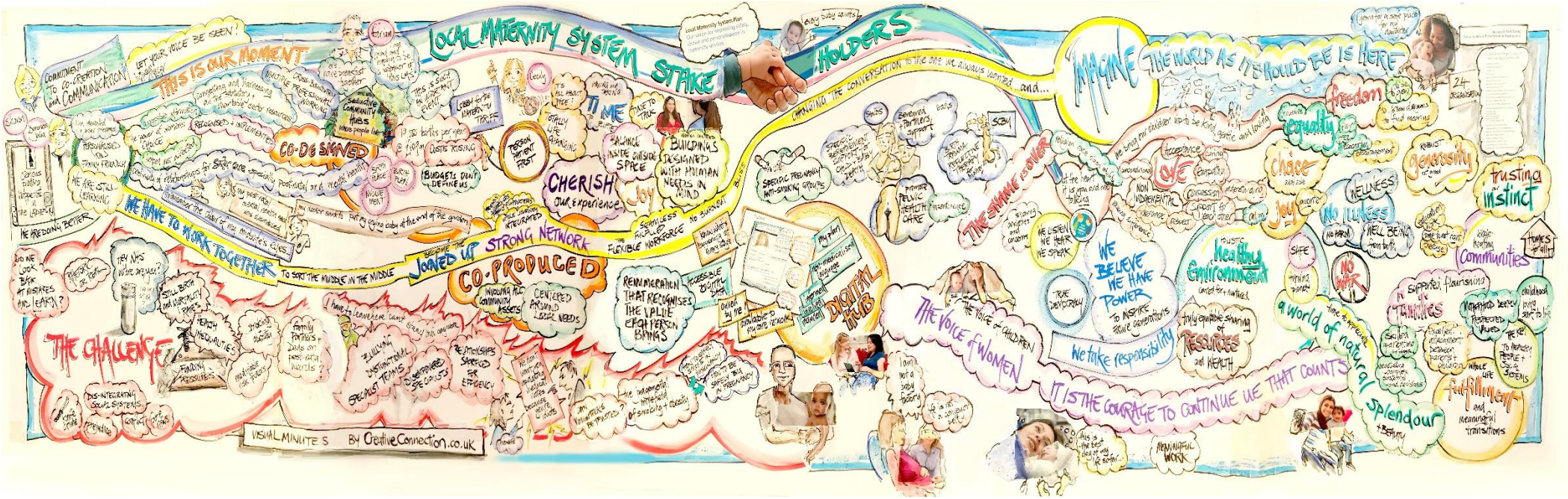


Figure 57: LMS Vision

Key priorities

There are a number of key priorities across our LMS which are briefly highlighted below. For more information on all areas of the maternity strategy, please see additional documents including the Sussex and East Surrey LMS Transformation Plan and LMS Smart Action Plan 2019.

Perinatal health

Whilst pregnancy is not an illness, the antenatal, birth and postnatal periods can sometimes be far from straightforward, requiring robust management and coordination of care. The LMS Plan focuses on partnering more closely with service users and understanding their personal needs. There are a number of factors which can influence the delivery of maternity care, some of which are lifestyle choices. Optimising a healthy weight, stopping smoking, eating well and looking after your mental health and wellbeing before, during and after pregnancy will positively support mothers and babies.

Smoking rates are variable across the LMS in different areas and within different population groups within Sussex. We are working in partnership with our population to support smoking cessation by training our midwives to provide advice and refer patients for further support. For more information on smoking cessation, please see section 6 on Prevention.

People's wellbeing and mental health needs vary throughout their lives and particularly during pregnancy. Our maternity transformation programme focuses on enabling staff to work with women to identify their needs and any changes in these needs throughout pregnancy, birth and after they have given birth. To achieve this, we are working to improve perinatal mental health knowledge and skills amongst our maternity and neonatal workforce, as well as addressing the gaps we have identified in the support available.

Safety

Safety is a key concern for everyone. The LMS has a very specific and important role, being a partnership of organisations, in ensuring our maternity services are working to the latest safety standards, identifying where there is variation in outcomes, tackling this collectively and sharing learning across our trusts. Working together on common problems, the LMS can pool its clinical, service user and professional expertise to address common challenges.

Personalised care

Being supported to make decisions and express choice throughout the maternity journey is key in building trusting relationships between health professionals and service users, and the development of personalised care plans enables this to happen. In addition, the Continuity of Carer model of midwifery care continues to develop, with the LMS aiming to ensure that at least 51% of service users receive this model of care by March 2021. Targeted Continuity of Carer will be available to 75% BAME, deprived and vulnerable groups within Sussex by March 2024 to address health inequalities for these groups. All of this work significantly impacts our midwifery workforce, and the LMS is leading the partnership work to support our midwifery teams to deliver Continuity of Carer in a way that both supports service users and ensures midwifery wellbeing. Our Heads of Midwifery are actively listening to our service users, working with our Maternity Voices Partnerships, service user representatives and their teams to develop innovative models which will work for all.

Choice of place of birth

As well as providing care that is more personalised, we are working with system partners to increase births in midwifery settings, as the national target is to ensure 100% of women booking with a trust providing maternity services can choose from three types of place of birth: home birth, midwifery-led bedded service/unit, and obstetric led bedded service/unit, from their provider. Currently, Brighton & Sussex University Hospitals does not provide service users booking with their maternity service a midwifery-led bedded service. This means that currently in Sussex only 67% of maternity service users have three choices of place of birth. There is potential for the MLU to be co-located with one of the two Consultant-led units in order to provide the choice of three types of place of birth to choose from when they book and throughout their antenatal maternity care. Services are being reviewed across Sussex to put forward proposals to address this issue.

Public engagement

The LMS ensures that our improvements are rooted in co-design through engaging with service users through surveys and Maternity Voices Partnership (MVP) representatives. Sussex funds five MVPs across the LMS geography, ensuring there are service user representatives as partners at all meetings, decision making forums and workstreams. Each of our MVPs has a programme of work to connect with the population they represent and ensure they can act as their voice, to work with their local trust to ensure experience informs improvements, and to bring this to the LMS-wide work.

Digital interdependencies

The LMS will continue to work closely with NHS Digital to improve digital maternity services in line with the Better Births recommendations and the Long Term Plan. The interoperability of both internal and external hospital systems is a key improvement that will enable clear communication between healthcare professionals, improving safety and reducing risk. The implementation of new updated maternity systems will improve data quality, which in turn will enable more robust reporting, better targeting and monitoring of specific groups, and support the reduction of health inequalities. For more detail please see the digital workplan for maternity.

DRAFT

7.4.2. Children and young people

As a system, we are committed to providing a strong start in life for our children and young people. Our strategy is one for our whole population which should support the journey from birth to old age. We are addressing a number of commitments for children and young people at place level, where these commitments involve local integration of services and co-production with children, young people, families and carers. Place-based development of age-appropriate integrated care is the optimum method for integrating physical and mental health services, enabling joint working between primary, community and acute services, and supporting the transition towards adult services.

We encompass wide variation in outcomes for children, including in relation to child poverty, where rates range from 7.3% in Horsham & Mid Sussex to 22.7% in Hastings & Rother. Obesity is also an issue locally, which reflects the national picture, as 7.8% of reception pupils and 15% of year 6 pupils were measured as obese across the Partnership, with higher proportions within deprived areas. Brighton & Hove also faces particular challenges, with the highest percentage of 15 year olds who smoke or have tried cannabis in England and the 3rd highest percentage of 15 year olds who drink weekly.

Integrated care, enabling primary, community and acute services

Our vision is to provide more responsive support for children and young people when they experience poor mental health or are in crisis so that they can access services when, where and how they choose, embracing digital and social media.

An important facet of integrated care is working together to deliver physical and mental health services. Due to increases in funding for children and young people's mental health, there is more focus on self-harm and the A&E pathway to keep children and young people healthy through building resilience. For example, the Alex Children's Hospital has developed a multidisciplinary approach to children and families, which is expanding to include the current team for Chronic Fatigue Syndrome/ ME in order to build up a more robust and inclusive service. Similarly, West Sussex's 'Find It Out Plus' programme is an integrated hub approach to emotional wellbeing and mental health for young people.

A key component of better integrated care for children and young people is close working with the local authority to support integration of health, social care and education needs. For example, Brighton & Hove is moving towards joint delivery and joint commissioning of children's community services with the local authority. East Sussex is looking to integrate disability pathways for children and young people across education, health and social care needs.

We are using data to target interventions at vulnerable groups which includes considering LGBT children and young carers. Through our places, we are also engaging a wide range of partners in primary and community settings to collaborate around a whole schools approach to build resilience and improve health and wellbeing outcomes for all pupils.

To be rolled-out at a Sussex level, NHS England will develop a national service specification for offering a digital child health record (e-red book) to help parents record information about their child's health. Local public health commissioners will support its implementation at a place level in conjunction with the local Child Health Information Services.

Our plans for learning difficulties and autism are also closely related to our provision of children and young people's services in Sussex – see section 6.5.3 for full detail.

More detail on the integration of children and young people's services can be found for each place in the Appendices.

Supporting transition to adult services

A more joined-up multidisciplinary approach as our children and young people transition to adult services is essential for increasing independence.

As we develop our PCN and primary care offer, there is an opportunity to enhance the support provided to young people outside of the current acute focus, particularly for those with complex health and care needs, as they transition to adult services. We will build upon our strong foundation in children and young people's mental health to develop a more integrated approach in this area.

We will also look to provide a holistic offer for our children and young people as they transition to adult services, including training support to colleges and work placements.

More detail on the transition to adult services can be found for each place in the Appendices.

7.4.3. Improving care for people with learning difficulties and autism

Learning difficulties (LD) and autism are a strategic priority for Sussex. We have a robust recovery plan which has been developed with partner agencies, with a significant level of executive leadership up to and including CEO level.

Major investment has been obtained in order not only to achieve the targets for people with LD and autism receiving inpatient care, but also to make long term and sustainable improvements to people's lives.

The Sussex Transforming Care Partnership (TCP) has also sourced additional resource to provide both capacity and expertise in improving systems, governance and oversight of the programme.

The Sussex TCP works across service providers, clinical commissioning groups and local authorities to improve services for people with a learning disability, autism, or both. We aim to make a real difference to the lives of local people, their families and carers, making community services better so that people with these conditions can live near their family and friends, and making sure that the right staff with the right skills are supporting them to do this.

Current state and challenges

Sussex TCP has made significant progress but also faces many challenges. We consistently have one of the highest inpatient populations within the Transforming Care Programme in the South East and a comparatively high proportion of people diagnosed with autism over the last year relative to the South East as a whole.

We know that training and awareness around autism has an impact on quality of care and outcomes for people, and we are supporting training with providers to make improvements in this area.

The Partnership has a relatively low usage of Locked Rehab beds in comparison to other TCPs in the South East, however we have seen a slow increase in average length of stay for all patients during their current placement. This has occurred while most other TCPs have experienced a decrease, causing Sussex to move from having the second shortest average length of stay to having the fourth highest in May 2019.

Sussex Steering Group are performing poorly on the LeDeR review relative to the South East. Of 179 notifications of death, only 23 have led to completed reviews, and within the Steering Group, three of the CCGs have reviewed less than 10% of deaths. All CCGs have failed to reach the total performance level of the South East.

We recognise the implications of LD and autism in terms of health outcomes, including a shorter average lifespan, and very significant health inequalities, and are committed to improving this through better analysis of mortality through the LeDeR programme, increasing the numbers of annual health checks in primary care, and developing more supportive community services.

However, Sussex also has many areas of strength, for example we have one of the highest Care and Treatment Review (CTR) uptake rates across the South East for adult inpatients, with 68% of adults having had a recent valid CTR.

Delivery priorities

Our delivery priorities for the next five years are as follows.

Involving people with lived experience and their families in checking the quality of care, support and treatment

We are committed to involving people with lived experience and their families in checking the quality of care, support and treatment and ensuring that all local services, including primary care and mental health, make reasonable adjustments for people with learning disabilities, autism, or both, when they need them.

We will continue the lived experience engagement project for those who have experienced inpatient care, including:

- Ongoing engagement with LD Partnership Boards and Speak Out advocacy group in Brighton & Hove
- Continued support for the Positive Behaviour Support network, with local patients and carers feeding experiences into meetings via case studies and films
- Involving people and their carers in capital development consultations
- Supporting the Children and Young People's TCP Working Group, which meets monthly and has parent representation
- Workforce planning and development which is key to making sustainable improvements in care, and as well as the autism training mentioned above. We are supporting providers to look at all options around recruitment and retention of staff, including apprenticeships.

Achieving the nationally set target for reduction in inpatient usage and beds

We have a collective inpatient number of 91 against a target of 50, and we aim to reduce this to at most 73 by March 2020 and 50 by March 2021. We will achieve this by further developing the Dynamic Support Register, increasing the frequency and effectiveness of CTRs, and increasing the number of case managers to deliver timely discharges and improved governance through monthly multi-agency discharge planning meeting.

We have developed a robust recovery plan to achieve the target for people receiving inpatient care, and improvements have already been made with 13 discharges already planned and on track between now and the end of March. Further discharges are actively being planned. Joint funding from NHSE and the CCG have enabled significant investment to improve skills and capacity to achieve this.

We have a dedicated housing team who are focused solely on breaking the log-jam of obtaining housing and care support by developing the provider landscape, solving problems and managing relationships across statutory and third sector organisations. We have also secured high level LGA support for two days a week to help us work across the system around housing and the local social care market, and to increase the effectiveness of working practices with colleagues in local authorities.

We are also committed to ensuring the principal aims of the TCP programme are achieved and that people who are unnecessarily in inpatient settings are supported in the community. We have reviewed the list to ensure we focus on the most appropriate individuals for discharge, while having oversight of all. We aim to reduce reliance on inpatient care for people with a learning disability and/or autism, with our targets set out in further detail in the Strategic Planning tool.

Monthly face-to-face discharge planning meetings are held in all three local authority areas and the proactive multi agency input is having an impact in pushing forward the often complex discharge process.

We have strengthened our governance arrangements and have an assurance process in place with Anne Eden and Adam Doyle providing executive oversight. We have made significant progress on delivery planning, with Moorhouse providing project support, increased provider engagement, and a workshop with providers planned for October 2019.

Achieving the target for physical health checks for at least 75% of people aged over 14 with a learning disability and/or autism

The delivery of an effective dynamic support register will provide proactive management of escalation and the ability to respond quickly and effectively in cases where adults, children or young people in the community are at risk of being admitted to inpatient settings. We will work with Primary Care Networks, enlisting the cooperation of Beacon Sussex GP practices (currently at or above 65%) to work in partnership with lower performing practices, with reimbursement, via reallocation of the DES payment. We will target a 20% increase based on current performance by March 2020, and a 50% increase by March 2021, aiming to achieve the national target by 2023. Further information on our targets is set out in the Strategic Planning tool.

The STOMP and STAMP initiatives are being led by our LD commissioner and are making improvements to prescribing practices in the care of people with LD and/or autism in

partnership with prescribing and primary care clinicians.

We will continue to deliver the local LeDeR programme and increase the number of Learning Disabilities Mortality Reviews, increase the current pool of reviewers and ensure dissemination of learning and embedding good practice via steering group and mortality meetings. Additional administrative support will be provided in order to source and process records.

Proactive case management

The TCP is recruiting to some key roles which will see team capacity enhanced by additional case managers, support for both care and treatment reviews, and establishing the dynamic support register. This will provide the capacity to not only progress current discharges and delivery of community supported living but also identify risk and more effectively support people already in the community.

Children and young people

The rate of ASD diagnosis is increasing and the challenges are significant. The TCP is working with lead children's, LD and mental health commissioners to improve the service we offer to children and young people, particularly in relation to transfers from children's to adult services, SEND and education health and care plans, children in residential special schools who have a higher risk of inpatient episodes, and improving education and employment opportunities.

7.4.4. **Reducing unwarranted clinical variation**

Programme structure

As identified by our Population Health Check, we have pockets of significant unwarranted clinical variation across our footprint. Sussex Health and Care Partnership established a system-wide Unwarranted Clinical Variation (UCV) Programme, with a commitment to work collaboratively to co-design evidence-based pathways and deliver value across the footprint.

The UCV Programme Team have been working in alignment with the ambitions set out in the Long Term Plan, and with multi-stakeholders across the Sussex geography, to identify opportunities to address the unwarranted clinical variation and deliver effective, high quality patient-centred care, resulting in:

- Improved Quality of Care
- Improves Health Outcomes
- Improved Shared Decision Making between Patients and Clinicians
- Improved Value, achievement of best possible outcomes for individual patients and for the public within available resources.

Based on the findings from our *Right Care* and *Getting It Right First Time* benchmarking data, and in line with the commitments in the Long Term Plan, we are currently targeting three priority areas over the next five years: Cardiovascular, Musculoskeletal and Falls. These current priorities are based upon our benchmarking data and address areas where variation is widest across Sussex. However, we have future ambitions to expand the scope of this programme over the next five years, including to cover more CVD commitments, not

just those where our variation is currently widest. As inequalities are a significant focus of our Sussex strategy, all workstreams are expected to address inequalities in access, treatment and experience, and information related to inequalities can be found within individual clinical sections of the strategy, e.g cancer and mental health.

Cardiovascular services

Challenges

- A higher rate of elective angiography and stenting for stable angina in Sussex, despite a lower estimated prevalence of angina
- A higher rate of diabetic foot amputations than the national average
- Variability in the identification and management of Atrial Fibrillation and stroke prevention
- Referral, uptake and completion rates for cardiac rehabilitation lower than the 70% target.

Future vision

By 2023/24 we will have:

- Reduced the number of people to have suffered from stroke through the delivery of proactive diagnosis and optimisation of anticoagulation treatment of Atrial Fibrillation, which will be widely available across Sussex Health and Care Partnership's population.
- Increased the number of people who are conservatively managed for their stable angina through establishing NICE care pathways that deliver CT coronary angiograms where clinically appropriate, and non-invasive functional testing by means of investigation first line where stable angina cannot be excluded by clinical examination alone. This will result in a reduction of third line invasive angiograms, as well as elective stenting of coronary arteries for treatment of stable angin,a as NICE recommended medical management first line, with the exception of a small high risk group.
- Established diagnostic pathways for stable angina that deliver CT coronary angiograms and, if required, non-invasive functional testing, to reduce invasive elective angiography and stenting according to NICE guidance.
- Streamlined access to echocardiography in primary and/or community care, supported by an expanded trained workforce of Cardiac Physiologists to meet the demands of service, thus negating the need for secondary services/interventions.
- Offered cardiac rehabilitation to all appropriate patients with cardiac disease, increasing the referral, uptake and completion rate to 70%, with an associated reduction in cardiac related admissions and improvement in outcomes.

Delivery planning

In order to achieve this, the CVD programme will initially focus on four priority areas, with work commencing from October 2019 onwards:

1. Development of a NICE guidance **standardised referral, diagnostic and management pathway for stable angina**, using CT angiography as the first line, where clinically appropriate
2. Co-design of a **pathway to improve identification of AF and optimised anticoagulation of AF**, thereby reducing incidence of stroke
3. Pilot schemes to **improve early access to echocardiography** to improve investigation of those with breathlessness and the early detection, and therefore evidence-based management, of heart failure and valve disease

4. Testing of technology to increase the referral and uptake of cardiac rehabilitation.

Ambitions for CVD

Our future ambition is to expand the current scope of our UCV CVD programme to cover not just the areas where variation is more prevalent across Sussex, but also individual cardiology, stroke and respiratory programmes, to report to the unwarranted clinical variation board. This proposed structure would enable us to cover further LTP commitments related to CVD from 2020/21 when fair shares funding becomes available, such as: increasing the numbers of people treated for hypertension and high cholesterol; rehabilitation services; and more effective use of technology and innovation, including linking with the NHS genomics programme on expanding access to genetic testing for Familial Hypercholesterolaemia (FH). Our immediate focus on stable angina pathways, improving identification of AF, improving access to echocardiography, and using technology to increase uptake of cardiac rehabilitation will be re-evaluated in line with our proposed updated governance structure, which would give greater prominence to CVD treatment across Sussex.

We are committed to expanding our CVD services over the next five years to offer a comprehensive service across primary, secondary and tertiary care which delivers improved treatment and support. We will support the national roll-out of the CVDPrevent Audit when this occurs from March 2020. As the British Heart Foundation and Ambulance Service roll out defibrillator networks, we will work with these services towards the goal of improving out of hospital cardiac arrest survival to 25%. We are committed to stronger working with our voluntary partners, including with the British Heart Foundation through the Cardiac Rehab Network in Sussex and Surrey. We also look forward to taking advantage of further opportunities as the national CVD and respiratory programme develops the service specification for STEMI heart attacks.

Musculoskeletal services and planned care

Challenges

- Higher primary total hip and knee replacement surgical intervention rates, despite similar rates of osteoarthritis
- Poorer post-operative health gain
- Current fragility of MSK services across Sussex.

Future state

By 2023/4 we want to consistently deliver the best value MSK pathway within Primary Care focused on empowering self-management and conservative treatment approaches with appropriate and effective use of onward referral/post-operative rehabilitation. Based on their individual needs and choices, people with MSK conditions will have access to early treatment for their condition and support to develop the knowledge, skills and confidence to self-manage their condition and maintain their independence.

Changes to the MSK pathway are already having a significant effect on the sustainability of Trauma and Orthopaedic services in secondary and tertiary care settings, which have the potential to become more acute as a result of the pathway changes proposed. Under the auspices of the Sussex Acute Collaborative Network, we will put forward proposals to manage the transformational change required in order to ensure a sustainable future for

these services across Sussex.

By 2023/24, we will have:

- A First Contact Practitioner workforce covering 100% of the population of Sussex.
- Provided access for people with MSK conditions, based on their individual needs and choices, to early treatment for their condition and support to develop the knowledge, skills and confidence to self-manage their condition and maintain their independence.
- Reduced growth in demand for GP consultations for MSK conditions, MSK medicines and imaging, physiotherapy, specialist MSK referrals and elective MSK surgery through delivery of a First Contact Practitioner model which will provide earlier assessment and management largely through conservative treatment options. This will also lead to better integration of services alongside use of an integrated digital record.

Delivery planning

The MSK UCV Programme of Works commenced in March 2019. To date, two large oversight groups, consisting of 50-60 people, have been held with stakeholder representation from every MSK Provider Health and Care Organisation across Sussex to begin to co-design MSK pathways.

Using Right Care and GIRFT data we have mapped current resources/pathways and identified gaps and opportunities for improvement across the system. Using a Best Possible Value decision charter, stakeholders have subsequently collaboratively agreed that the initial focus will be to co-create the best value evidence-based initial MSK pathway within wider Primary Care. This will be focused on empowering self-management and delivering conservative approaches, supporting, where appropriate, onward referral and post-operative rehabilitation.

The preferred solution option for a Sussex-wide First Contact Practitioner service model has now been defined and, following due governance and sign off, operational delivery will commence from April 2020. The solution will be tested for one year with regular evaluation/monitoring of impacts, with a view to longer term delivery from April 21 onwards.

Falls and fragility fractures

Challenges

- 3,100 additional falls in the over-65s in Sussex and East Surrey during 2017/18
- Higher rate of injuries due to falls in the over-65s compared to our demographic peers.

Future state

The LTP sets out plans to work on falls and fracture prevention, whereby a 50% improvement in the delivery of evidence-based care could deliver £100 million in savings nationally. The UCV Programme of Works supports this ambition and aims to have achieved the following by 2023/24:

- Significant savings by Year 5 through successful delivery of falls prevention services and fracture liaison clinics

- Reduced demand for care through increased falls prevention.

Across Sussex, our aims are:

- A reduction in injuries due to falls among the over-65s, and therefore in activity and spend related to this in ED and NEL admissions
- Increased opportunities for people aged over 50 to access physical activity
- Improvement in bone health, and identification and treatment of osteoporosis, through equitable access to Fracture Liaison Services
- Increased appropriate referrals, according to risk, to evidence-based Strength and Balance classes, and multifactorial falls risk assessments
- Redesigned pathways to deliver timely support and response to people who have fallen at home, and a subsequent reduction in ambulance call-outs and response times to non-injured falls at home
- Improved falls prevention knowledge, skill and confidence in the over-65s
- Implementation of a consistent universal Home Hazard assessment.

Delivery planning

The Falls and Fragility UCV Programme of Works commenced in April 2019. Two Falls and Fragility oversight groups were held during April and June 2019 involving approximately 50-60 multi-professional stakeholders coming together to shape and scope opportunities to improve and drive value in falls and fragility fracture services across the STP footprint. The Best Possible Value Toolkit was implemented within each workshop to enable co-design of future services and pathways, demonstrating value through agreeing the context for change and identifying the key objectives to be achieved by the service/pathway redesign.

Together with our stakeholders, we have made a series of commitments that we will implement over the next five years:

- Delivery of increased Strength and Balance Programmes to reduce falls by 34%.
- Implementation of a Sussex-wide Single Point of Access to falls prevention services, ensuring that a person receives the right treatment first time.
- Development and implementation of standardised Home Hazard assessments to reduce recurrent falls after hospital attendance for a falls related injury. Expected Return on Investment of £1:£3.17.
- Equity of Fracture Liaison Services to reduce secondary fractures by 50%.
- An approach to supporting Ageing Well and improvements in bone health.
- An approach to reduce response times to ambulance calls for non-injured falls at home.

Participants in the stakeholder workshops concluded that there was a need to establish four short-life ‘Task and Finish’ groups to undertake some specific focused work to co-produce and redesign those elements of the pathway relating to the initial priority areas identified, namely:

- **Non-injured falls at home**: a focus on improving response times and reducing long-liers as well as referral onward to falls prevention services
- **Low level falls prevention & osteoporosis identification**: a focus on ageing well, improving bone health, identifying people at risk of falling, and empowering them to attend evidence-based falls prevention services, such as strength and balance programmes

- **Falls prevention post A&E attendance or hospital admission for a falls-related injury**: focus on onward referral to Home Hazard assessment and falls prevention services
- **Fracture liaison service development**: a focus on developing and standardising our identification of fragility fractures, osteoporosis treatment to reduce further fragility fractures and onward falls prevention.

Governance

The Unwarranted Clinical Variation Programme Board has oversight of the MSK, Falls and Fragility Fractures and Cardiovascular Boards and reports to the Clinical and Professional Cabinet. We have an executive sponsor, SRO, and clinical and programme leads who are driving forward our three priority areas. The governance structure and responsibilities of the UCV board are detailed below:

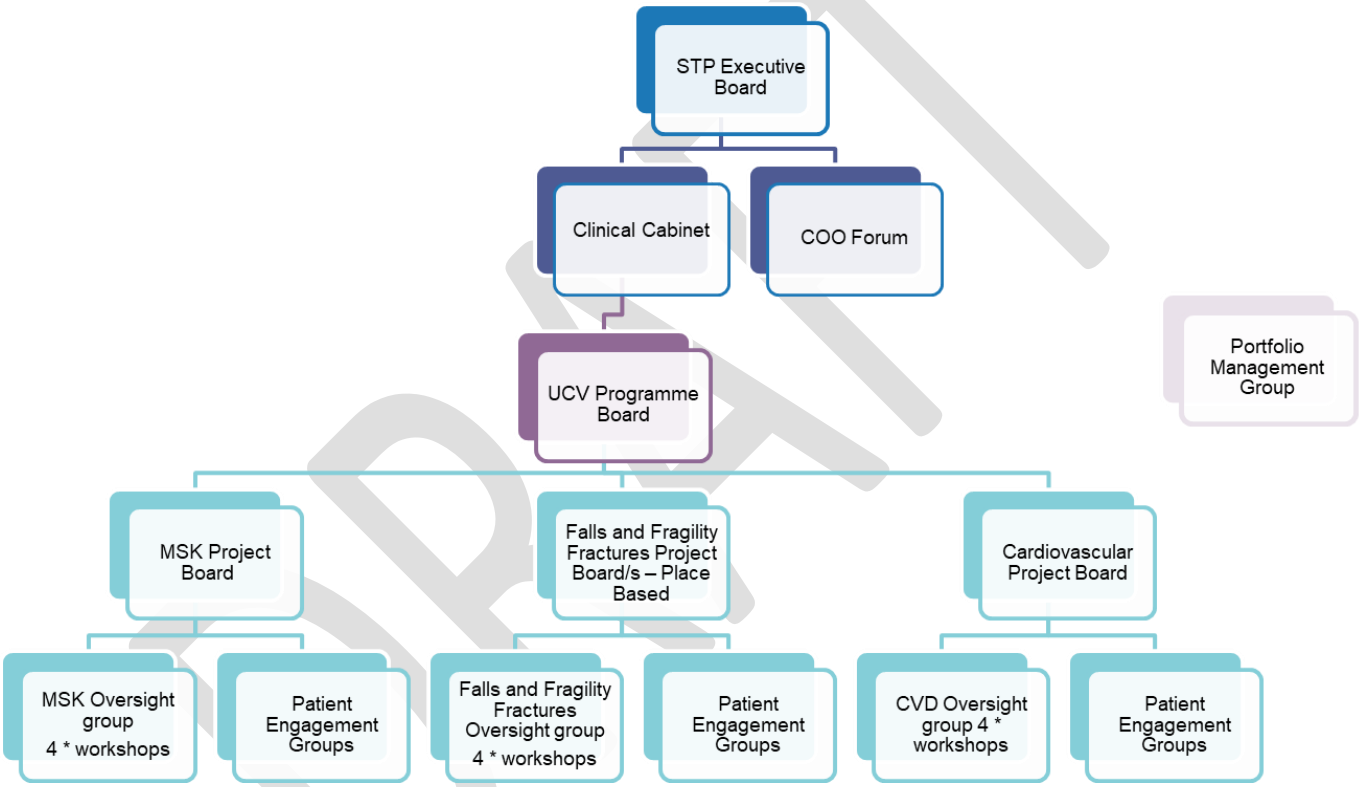


Figure 58: UCV governance structure

Approach and decision making framework

A common approach to programme delivery across the three priority areas was agreed at the outset which entails overarching governance and oversight of the programme as a whole, with a bottom-up collaborative approach to design. As part of this it was agreed that we would hold a series of four multi-agency/multi-professional workshops or 'Oversight Groups' per pathway, which are large forums involving all providers and commissioners in order to:

- Gain a shared understanding of the issues and opportunities
- Co-produce evidenced-based solutions to the unwarranted variation
- Develop and agree an overarching service model and pathways.

The UCV Programme has identified the Best Possible Value (BPV) Toolkit as an appropriate

framework to help drive a common approach to collaborative decision making and has been subsequently endorsed by the UCV Programme Board. This approach aims to support:

- A value-based approach when redesigning services.
- Clear processes to improve the speed and ease of decision making
- The evaluation of options on the merits of maximising value
- Achievement of best possible outcomes for individual patients and the public within available resources.
- Implementation of agreed decisions sooner and with the support of all stakeholders.

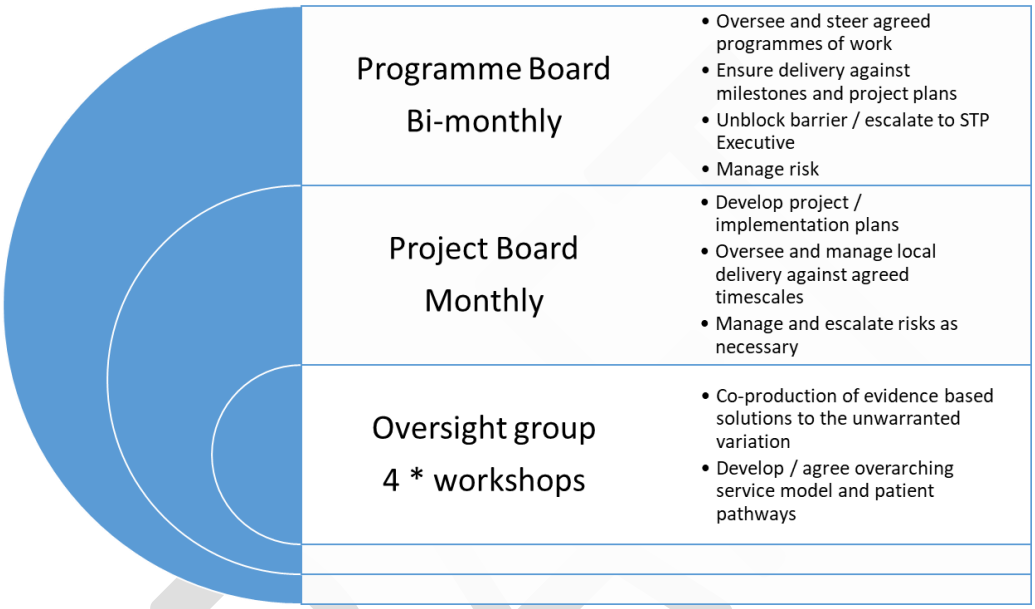


Figure 59: Responsibiltiies of the Board

Summary roadmap for the next five years

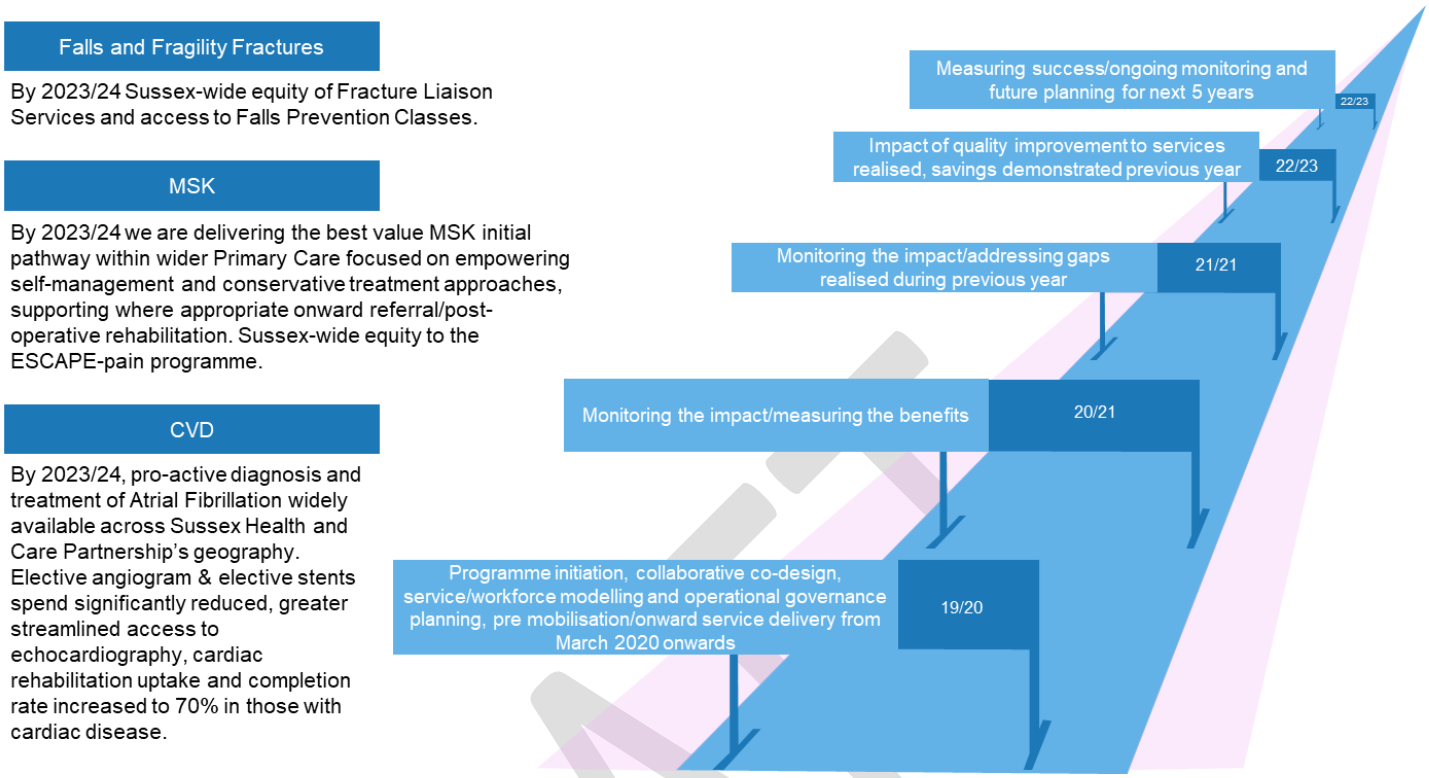


Figure 60: UCV summary roadmap

For more information on the five year phasing of our actions to deliver our priority programmes, please see Appendix A. For further CVD commitments not prioritised for 2019/20, a detailed roadmap of actions and trajectories will be developed following the proposed expansion of the scope of the UCV programme.

Stakeholder mapping & engagement

The UCV Programme Team have recently developed an overarching Communications & Engagement strategy which aims to consult, engage and fully communicate the idea and concept of UCV and the workstreams to a variety of internal and external stakeholder audiences. It will build people's trust and confidence in the work taking place, the proposed new model(s), and how it impacts them, their work and their health and care.

Information provided will be clear, convenient to access and easy to find. We will use those channels already known to our target audiences:

1. **For internal CCG staff** – minimise duplication and link up interdependencies between programmes of work through the CCGs in Sussex
2. **For providers** – streamline activity to reduce variation in care/access to services
3. **Public and patients** – promote health and wellbeing and inform/engage patients in any changes in NHS care/services.

7.4.5. Better care for major health conditions

The following major health conditions are specifically addressed because they are key priorities in the NHS Long Term Plan and represent a significant proportion of the long term conditions prevalent amongst our population. We also have a large number of programmes working to improve care for other major health conditions for our population which are not mentioned in this section.

Stroke

Current state, challenges and commitment

Stroke, a preventable disease, is the fourth single leading cause of death in the UK, and the single largest cause of complex disability. Stroke mortality has halved in the last two decades but, without further action, due to changing demographics the number of people having a stroke will increase by almost half, and the number of stroke survivors living with disability by a third, by 2035. Across Sussex in 2017/18, there were 2,566 stroke-recorded admissions on the Sentinel Stroke National Audit Programme (SSNAP): with no action, this number could rise to 3,849. In Sussex, we have made some significant progress transforming our stroke pathways which is reflected in our Stroke Sentinel National Audit Programme (SSNAP) scores, however we are committed to going further and faster to improve the outcomes for our patients with best practice personalised pathways.

Governance and delivery mechanisms

The delivery vehicle responsible for driving improvement and transformation will be the newly formed Integrated Stroke Delivery Network (ISDN), which will be implemented by April 2020. The new ISDN will provide a clinically-led, robust and integrated governance framework to support and assure the implementation and delivery of the new National Stroke Service Specification. The governance arrangements and infrastructure will be in place by March 2020. The ISDN geography has not yet been finalised, but we will work closely with neighboring ISDNs to manage patient flow across boundaries, including close collaboration with SaSH.

We are committed to actively involving stroke survivors, their families and carers in discussions and decisions about stroke care, in addition to our local voluntary and community sector partners such as the Stroke Association. We will establish suitable patient involvement and co-production arrangements so that people at risk of, or who have experienced, a stroke are represented from the outset in the governance arrangements of the new ISDN.

Our local ISDN will also be responsible for setting clear expectations across Sussex and leading local consultation and decision making on proposals for stroke service transformation. It will have three key deliverables:

- Best practice personalised stroke pathways configured and managed from pre-hospital care onward, including ambulance, thrombectomy, Early Supported Discharge (ESD) and six-month reviews within initial implementation, building to include the full pathway from prevention through to life after stroke
- A flexible, future-proofed competency-based stroke workforce delivering stroke care 24/7, supported by a skills and capabilities framework and toolkit
- A comprehensive dataset meeting the needs of clinicians, commissioners and

patients, describing the quality and outcomes of care provided and ensuring that all providers are effectively inputting into SSNAP.

Our aspirations in Sussex

Prevention - We will deliver a more individual-centred approach focusing on prevention to align with the Sussex-wide CVD prevention strategy to reduce health inequalities. The ISDN will work with community pharmacists, GP practices, and voluntary sector partners such as the British Heart Foundation and the Stroke Association, to raise awareness of stroke and its symptoms, as well as risk prevention. This could include, for example, increasing the number of people treated for high blood pressure and cholesterol.

Whist we have seen improvements in relation to the identification and management of Atrial Fibrillation (AF) there are still an estimated 13,750 people with undiagnosed AF within Sussex. The ISDN will continue to work closely with Primary Care Networks and the Sussex-wide UCV programme so that by 2021/22 we have a consistent approach across Sussex, with direct learning from the CVDPREVENT audit. Our longer-term aim within our prevention strategy is that, by April 2029, 85% of the expected number of people with AF are diagnosed and 90% of patients with AF who are known to be at high risk of a stroke are adequately anticoagulated. The impact of this will be 436 fewer strokes across Sussex.

Acute care – The Sussex acute care plans will ensure that we maximise patient care and system sustainability via service transformation and reconfiguration. We will work closely with SECAmb during 2021/22 to deliver robust transfer pathways including category 2 intra-hospital transfers for potential thrombectomy patients. This will include training and operational capacity to support the increase in thrombectomy at Brighton and Sussex University Hospitals (BSUH) and the acute service transformation planned in West Sussex for 2021/22. Capital funds are also being considered.

By 2023/24, we aim to have increased the provision of stroke thrombectomy for 10% of patients. We are committed to increasing mechanical thrombectomy provision from an ad hoc five day service to a comprehensive 24/7 service over a period of six years at the Brighton and Sussex University Hospitals (BSUH). This would increase the number of thrombectomies from 29 (2017/18) to 359 by year six. This modelling assumes thrombectomies from BSUH, East Sussex Healthcare, Western Sussex Hospital Trust, East Surrey Hospital and Tunbridge Wells Hospital (Pembury) are referred to BSUH (Royal Sussex County Hospital) for treatment.

By 2021/22 we will have all acute stroke system transformation completed across Sussex, with all stroke services delivered in fully compliant HASU/ASU units delivering sustainable 7 day services with a competent reshaped workforce to enable consistent achievement of overall quality marker of SSNAP A performance across all systems. We will deliver thrombolysis to at least 15.8% of stroke patients and stroke unit care in less than four hours for at least 80% of all stroke patients, in order to reduce disability and increase survival after a stroke. Further detail on our targets is set out in the Strategic Planning tool.

The ISDN will also ensure that TIA and stroke ‘mimic’ activity, including neurology patient flow, is considered within all service modelling, development and transformation, and that we

develop plans for the implementation of AI imaging software in line with the national pilot outcomes.

Rehabilitation – The ISDN will work to ensure that Sussex delivers the new national standards for both inpatient and integrated community rehabilitation services in 2020/21. We will implement the Early Supported Discharge (ESD) pathway for Coastal West Sussex during 2020 and meet the 40% ESD standard across Sussex by 2021/22.

We will adopt the new national CQUIN and ensure that all stroke survivors across Sussex are appropriately offered a six month post stroke review with a minimum of 60% uptake by 2021/22. We will ensure that data is systematically collected from the six month reviews across Sussex and used to inform local needs mapping, as well as workforce and service improvement planning, for 2020/21 and subsequent years. Further detail on our targets are set out in the strategic planning tool.

The ISDN will also pull together a comprehensive offering for Stroke Survivors and their families and carers, supporting engagement and access to long term rehabilitation including self-management, vocational support, psychological support and social prescribing, with the aim of improving community integration.

Diabetes

Current state and challenges

Across the Sussex Partnership, the healthcare system faces a number of significant challenges relating to the delivery of diabetes care. We have a diverse population with extreme variations in terms of socioeconomic status, health outcomes, environment and economic prosperity, all of which are linked to health inequalities and outcomes.

East and West Sussex have a much older population profile than the country as a whole, whilst Brighton and Hove have a younger population profile. Poor diet has been identified as one of the top five factors driving variation in outcomes, alongside smoking rates, lack of physical activity, alcohol misuse and mental health problems.

We face challenges in meeting constitutional standards; for example, while NICE recommend referral and triage within two days, 83% of our patients wait more than two days and 38% wait at least 14 days.

Diabetes outcomes also have significant variation, with a wide variation in amputation rates across Sussex, and the diabetic amputation rate expected to continue rising. The average number of major amputations in England is 8.1 per 10,000 (standardised rate). Across Sussex, the rate ranges from 5.8 in High Weald Lewes Havens CCG to 10.2 in Eastbourne, Hailsham and Seaford CCG. The average number of minor amputations in England is 20.7 per 10,000 (standardised rate). Across Sussex, the rate ranges from 17.7 in Crawley CCG to 28.9 in Eastbourne, Hailsham and Seaford CCG.

There remains a gap in the actual to expected prevalence rate of diabetes across all CCGs. To address this we are focusing on primary care screening for diabetes, with some CCGs providing financial incentives to encourage this.

5-year Vision

The Sussex Diabetes Programme has been established to support each place within our footprint to identify commissioning gaps, deliver improvements in the services each place offers, deliver improvements in the health outcomes of people living with diabetes, and reduce unwarranted variation.

Our aim is to create a sustainable system of diabetes care within Sussex that supports the prevention of diabetes, allows people living with diabetes to easily access high quality services when needed, supports people to self-manage, and attracts and retains the best diabetes workforce. We will also aim to work collaboratively with the newly established Sussex Health and Care Partnership Prevention Board to develop the public health interventions that could support primary and secondary prevention, with the long term aim of stemming the tide of preventable diabetes and encouraging greater self-care and understanding of people living with the condition.

Remit of the Programme

The Sussex Diabetes Programme is currently focused on six priorities to achieve our vision:

1. **Prevent Type 2 Diabetes Mellitus (T2DM)**

The Programme will support delivery of the National Diabetes Prevention Programme. A new NDPP provider is transitioning in and will go live in August 2019, and we have recruited an NDPP project manager. We have set targets for referrals that will contribute to the national DPP uptake, through the place-based commissioners.

2. **Improve diabetes footcare**

The programme will support the implementation of the Sussex Multidisciplinary Foot Project and seven day access to urgent consultant led foot services. Each place will have projects to recruit DISNs and ensure universal MDFT provision across Sussex, with clear links and pathways with the vascular hub.

Identified next steps include:

- Implement root cause analysis (RCA) process across all providers
- Install foot care champions on all wards (including digital solution to identify all inpatient diabetics)
- Develop foot care education offer for HCPs
- Commission peer review of foot services
- Embed clinical audit improvement across STP – NDFA and Harms

3. **Improve patient outcomes**

The programme will support the delivery of quality mental and physical health diabetes care, the achievement of CCG Improvement and Assessment Framework Targets, and reducing unwarranted variation. Our focus will include:

- Utilisation of the CCG Improvement and Assessment Framework
- Attendance at structured education in the prevalent diabetes population (%) (source: NDA)

- Achievement of the three NICE recommended treatment targets in patients with type 1 diabetes (source: NDA)
- Indirectly standardised 3-year rate of amputations in patients with diabetes (source: Public Health England)
- Directly standardised rate of bed-days for patients with diabetes admitted to hospital (source: Hospital Episode Statistics and NDA)
- Multidisciplinary foot care team coverage and diabetes inpatient specialist nursing service coverage across a CCG's commissioning footprint (source: NDA – National Diabetes Footcare Audit/National Diabetes Inpatient Audit)
- Achievement of NICE recommended treatment targets in children (source National Paediatric Diabetes Audit).

4. **Have fair and consistent policies for CGM/FGM**

The programme will support all SES CCGs to have compliant policies for CGM and FGM. The NHS Operational Planning and Contracting Guidance 2019/20 sets out requirements for the provision of CGM and FGM. Our plan is that, by 2020/21, all pregnant women with type 1 diabetes will be offered continuous glucose monitoring (CGM), helping to improve neonatal outcomes. In line with guidance, we have ensured that flash glucose monitoring is available for type 1 diabetes patients who meet the criteria.

5. **Support people living with diabetes to self-manage**

The Diabetes Programme will support the roll-out of a consistent, high quality digital self-management offer across Sussex. This will include:

a. Patients Know Best – patient held health record
b. DUK information prescriptions
c. Online Diabetes Self-Management Education (DSME) – T1DM, T2DM and transitioning patients

6. **Support frail older people to live independently and to improve outcomes in care homes**

We will support development of new inpatient nursing and proactive community nursing roles to support independence, and to reduce admissions, readmissions and length of stay. We will also support the development and roll-out of training and support packages to nursing homes to support good diabetes care in the care home environment.

Governance

Hastings & Rother CCG are the host organisation and budget holder for the Sussex Health and Care Partnership Diabetes Programme, and are responsible to NHS England for delivery of the programme, reporting into the Programme Board.

Key roles and responsibilities include:

- The STP programme manager and senior responsible officer (SRO) chair and administer of the STP Diabetes Oversight Group (DOG)
- The STP multidisciplinary foot project team are line-managed by the STP programme manager
- NHS South, Central and West Commissioning Support Unit provide business intelligence and analytics

- Hastings & Rother CCG Programme Management Office (PMO) provide PMO support on behalf of the STP.

Respiratory

In line with the national picture, respiratory disease is one of the greatest contributors to morbidity and mortality in Sussex. Our ambition is to shift activity closer to patients' homes, using a model of community and primary care services, improving early identification, and optimising management to prevent acute exacerbations and admissions.

To integrate respiratory services into the community model, places have been tasked with developing local responses to the commitments of the Long Term Plan and setting out their tailored approach to improving respiratory services and outcomes within their patch. A number of priorities are emerging from the current work within places, including scoping to offer the myCOPD app to patients more widely in collaboration with community teams. Longer term, our aim is for all our services to be able to provide community support to patients with a wide range of respiratory-related conditions, reducing the need for these patients to travel out-of-area for specialist aftercare.

Community respiratory services are also being developed and enhanced to reduce admissions from respiratory conditions and manage various levels of complexity of condition across primary care, general and specialist community services. The COPD, respiratory and chronic respiratory LCSs are being reviewed in Brighton & Hove and East Sussex to identify opportunities to enhance training, review medication, and scope alignment with currently-developing PCNs. By reviewing our training programmes and pathways, we can support staff to counsel patients and empower them to take a more active role in their care.

More detail on the implementation of respiratory service changes can be found for each place in Appendices A-D.

8. Supporting our workforce

8.1. Current state and key challenges

Workforce is critical to the delivery of the health and care strategy: we also know that, at present, the health and care system faces a number of challenges to ensuring that it has the workforce to achieve its current and future needs.

Key workforce challenges in Sussex:

- High vacancy rates – notably in a number of registered health professional groups such as nursing, medical staff and allied health professionals
- Higher turnover rates in recent years
- Insufficient supply of future staff to key roles based on current staffing models.

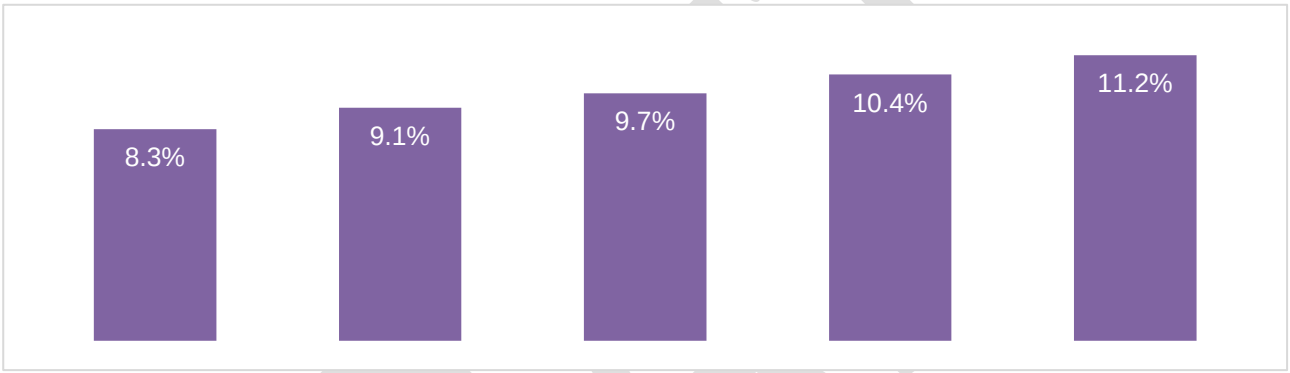
Leaders across the Sussex Health and Care Partnership are committed to working collaboratively to address these challenges and to deliver upon the commitments of the interim NHS People Plan through the development of our Sussex workforce plan, strategic priorities to 2023/24, and system approach to delivery.

8.2. Sussex workforce plan

The first step in developing our workforce plan has been to model what our workforce demand would be if we continued to operate using current workforce and operating models with a staff supply that continues to increase at the current rate. This default position for our workforce over the next five years has been commissioned by The Local Workforce Action Board (LWAB) and Finance Group to produce this *'do nothing'* model based on agreed activity growth from 2019/20 plans and agreed activity modelling. This demonstrates a growing workforce challenge over the next five years and is the baseline from which plans will be developed.

The tables below represent the overall and staff group forecast position in a 'do nothing' scenario, before the impact of the Partnership plans over the next five years.

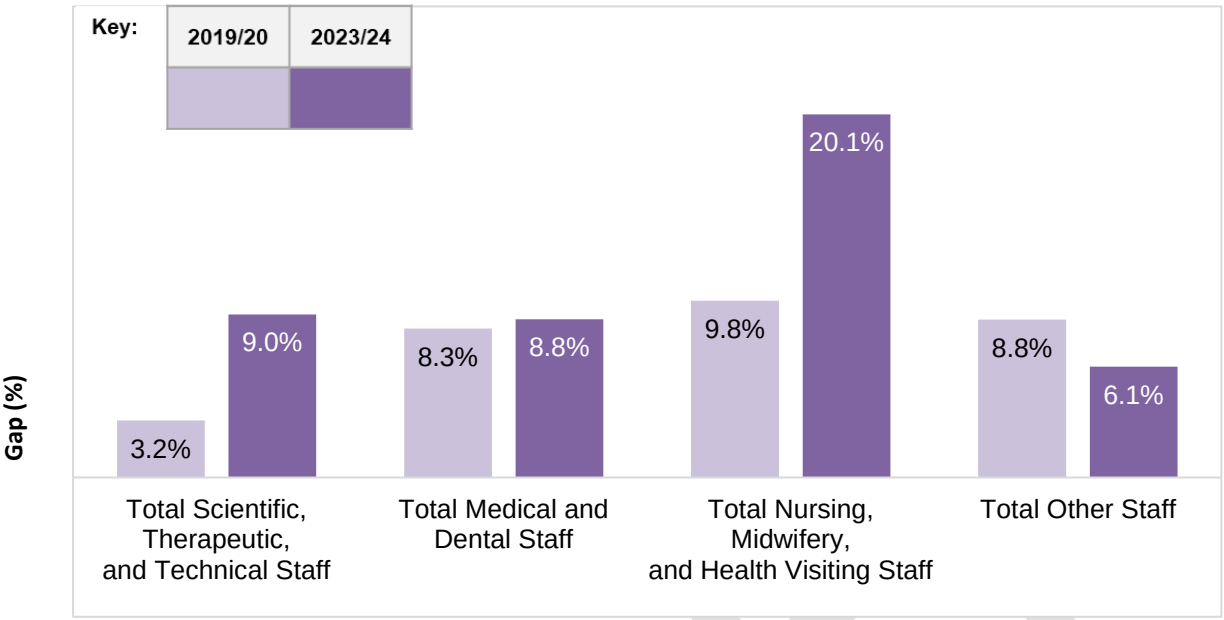
The 'do nothing' projection for workforce forecasts an overall 11.2% workforce gap in 2023/24, representing 3,920 WTEs.



	2019/20	2020/21	2021/22	2022/23	2023/24
Supply	29,542	29,908	30,308	30,732	31,182
Demand	32,208	32,910	33,558	34,308	35,103
Gap (WTEs)	**2,666**	**3,002**	**3,250**	**3,576**	**3,920**
Gap (% of demand)	**8.3%**	**9.1%**	**9.7%**	**10.4%**	**11.2%**

Figure 61: 'Do Nothing' workforce projection

The workforce gap is forecast to increase most significantly for Nursing, Midwifery and Health Visiting staff, to 20.1% in 2023/24



Gap (WTEs)	133	422	282	336	952	2,204	1,299	958

Figure 62: 'Do Nothing' workforce projection by staff group

Changes in workforce demand

There are a number of factors that will influence workforce demand in the next five years:

- Under the Additional Roles Reimbursement Scheme for Primary Care Networks, the primary care workforce has been modelled to increase by over 650 wte clinical pharmacists, social prescribing link workers, physiotherapists, physician associates and paramedics.
- NHS providers' organisational plans show that workforce developments will increase workforce demand by c.1,100 wte. This increase is based upon the plans of the system's mental health and community providers specifically, on the back of additional investment in these sectors. Acute providers' 'do something' workforce plans have not yet been worked up in sufficient detail to generate specific numbers for changes to their baseline workforce demand projections.
- More detailed workforce plans will be developed for Sussex-wide and place-based priority clinical programmes over the coming months, as details of operational plans and activity impact are developed and agreed collectively. These plans will consider the opportunities for new roles and new ways of working, including the opportunities for improving care through technology and digital.

Changes in workforce supply

The Partnership recognises the importance of developing plans to improve the future supply of workforce, particularly for key staff groups such as nurses and AHPs, where a training programme may take several years to complete. To address the supply of workforce:

- Partner organisations in Sussex are already collaborating to optimise use of the

apprenticeship levy as a new route into health and care careers, including, where appropriate, transferring the levy to other health and care providers
- Plans are being developed to promote health and care careers to the local population and to promote Sussex as a place to work and live
- We are reducing staff turnover – the approach to making Sussex the 'Best Place to Work' is described in more detail in the section below
- We are developing capacity to train more staff within Sussex
- We are developing new roles to manage demand differently and the associated education commissioning required.

Workforce plans will be developed to align with the Sussex Health and Care Strategic Model by supporting planning at neighbourhood, place and Sussex level. This will be vital for ensuring alignment of the workforce with clinical models, activity and finance, and for supporting the development of our new service model, taking into account the needs of PCNs and ICPs.

8.3. Workforce strategic priorities – delivering the interim NHS People Plan

The Sussex Partnership has recently reviewed and agreed strategic workforce priorities for 2019/20. The timetable for strategic priorities from 2020/21 to 2023/24 is outlined later in this section and is designed to align with system priorities and anticipated progress on the NHS People Plan at a national level.

The workforce workstream strategic priorities for 2019/20 are designed to align closely with the priorities within the Long Term Plan Implementation Framework and with key local needs. Our initial priority will be NHS employers, and we will work with other partners within the Sussex health and care system in the future to develop our workforce strategy further and to share and codify learning.

Our strategic priorities for 2019/20 are set out below under the following themes:

- Workforce planning, transformation and growth
- Making the NHS the 'Best Place to Work'
- Improving leadership culture
- Changing the Workforce Operating Model

Workforce planning, transformation and growth	
Strategic objective – 2019/20	**Our approach to achieving this objective**
Produce a workforce plan to 2023/24 aligned to activity and financial plans for Sussex Health and Care Partnership	The approach to workforce planning is described in the Sussex Health and Care Partnership workforce plan section above
Produce more detailed workforce plans for health professional groups – for 2019/20 the focus will be on producing a nursing workforce plan and AHP workforce plan	A detailed nursing workforce plan will be developed during 2019/20. This will outline plans to manage workforce demand differently (e.g. e-rostering efficiency, assigning clinically appropriate alternative roles to registered nurses, system transformation and workforce redesign) and to increase workforce supply (e.g.

	opportunities to increase international and domestic recruitment, improve retention, increase newly qualified nurses through universities and apprenticeships). A similar plan will be developed for the most challenged Allied Health Professionals staff groups.
Improve primary care workforce development by implementing the Sussex Partnership Training Hub development plan – focusing on improved workforce planning, engagement with Primary Care Networks, improved education quality assurance and governance	We have established a central team for the Training Hub and continue to invest in local training hubs. With the support of Health Education England, primary care team plans for Sussex-wide and local training hubs will continue to develop and learn from other STPs. The focus will be on supporting the current workforce and developing the future workforce, with a specific focus on the Primary Care Network workforce.
Implement reductions to nursing agency costs and agree a collective approach to reducing NHS provider medical agency costs	Whilst the workforce strategy is to reduce our overall workforce gap, we recognise there are opportunities to reduce current temporary staffing costs. The focus to date has been on reducing nursing agency costs, with additional reduction actions planned in 2019/20. We are also working with the NHSI/E temporary staffing team to develop our strategy to reduce medical agency costs.
Make the NHS the 'Best Place to Work'	
Implement a plan to improve staff mental and physical health and wellbeing, promote flexible working, reduce violence towards NHS staff, and adopt best practice to close the ethnicity gap in rates of disciplinary action	Whilst the NHS Staff Survey shows that staff experience in most NHS organisations in Sussex is better than the NHS average, we recognise there are significant opportunities for improvement to make Sussex the 'Best Place to Work'. We have developed a prioritised programme of work within the Health and Care Partnership to improve the experience of our staff at work, building on best practice within our system and learning from others. We believe that our collective approach will reduce staff turnover by at least 2%.
Undertake diagnostic on priority action to improve Black, Asian and minority ethnic (BAME) staff representation across the STP leadership team and	We recognise the importance of workforce race equality within employers in the Partnership, but also acknowledge from the Sussex-wide review of our current Workforce Race Equality Standard (WRES) position, that

broader workforce by 2021/22	we need to improve. We are working with the national WRES team to develop our workforce race equality strategy, including responding to the *Model Employer* strategy to improve BAME representation across the workforce pipeline and at leadership levels. The strategy will be shaped by a Sussex-wide event for chief executives, race equality leads and other senior leaders in November 2019, to identify priorities for workforce race equality and develop plans to address them. Our Best Place to Work Group is leading on learning from *A Fair Experience for All* to improve the fairness of disciplinary processes for all staff, and close the gap in the disproportionate rates of disciplinary action involving BAME and white staff within our organisations.
Improving leadership culture	
Establish and embed the cultural values and behaviours we expect from our senior leaders	Senior leaders in the Partnership recognise that positive, compassionate and improvement-focused leadership creates the culture that delivers better care, and that operating as an Integrated Care System will require a different approach to leadership. Defining the leadership cultural values and behaviours of senior leaders and how they will be embedded will be a focus within the ICS Accelerator programme.
Implement a system-wide approach for managing talent that aligns with Regional Talent Board	We recognise the importance of developing the talents of our staff. We are developing our approach to talent management with the support of the KSS Leadership Academy. We will ensure our approach aligns with the emerging approach of the NHS South East Regional Talent Board, established earlier in 2019.
Agree a prioritised leadership development plan for 'connecting layer' of management	We have a number of programmes within Sussex to support and develop leaders. These include the development of a Sussex coaching network and a leadership development programme for frontline leaders. These programmes are supported with funding from Health Education England and the KSS Leadership Academy. We are also working on a leadership development programme for the 'connecting' layer of management.

	The development of these programmes is overseen by a multi-agency staff development group involving NHS, local authority and other health and care providers.
Change the Workforce Operating Model	
Agree Integrated Care System level workforce responsibilities with NHSI/E and HEE, including a transition plan and future resources	We will develop our workforce operating model to transition to an ICS with NHSI/E, learning from the STP/ICS Workforce Planning Development Tool pilot sites.

DRAFT

8.4. Strategic plan from 2020/21 to 2023/24

This section outlines the phasing of the workforce workstreams in future years.

The future plans are phased to reflect Sussex workforce priorities and in anticipation of local devolution of actions from the final NHS People Plan. The phasing is subject to adjustment following publication of the final NHS People Plan and/or NHSI/E guidance.

The plan aims to initiate further actions between 2020/21 and 2021/22, with the focus in 2022/23 and 2023/24 on delivering the impact of the interventions started in the previous three years and refining their approaches.

Theme	2020/21	2021/22
Making the NHS the 'Best Place to Work'	• Embed actions to improve mental and physical health, reduce violence, and increase flexible working • Implement new NHS offer to staff • Implement actions from Sussex WRES diagnostic • Undertake diagnostic to improve disability equality using WDES • Introduce new NHS 'balanced scorecard' and metrics in NHS Oversight Framework	• Implement recommendations from national independent review of HR and OD practice • Embed actions from workforce disability diagnostic
Improving the leadership culture	• Implement new NHS Leadership contract • Continue to deliver STP leadership programmes • Review Partnership leadership programmes based on evaluation • Embed talent management systems • Increase number of participants in graduate management scheme in Sussex	• Support further maturing of talent management systems • Review impact of system-wide leadership programmes
Addressing urgent shortages in nursing	• Continue to implement Sussex nursing workforce plan – improved supply, new roles etc. • Increase nursing university clinical placements and engage with universities to facilitate further increase • Embed Sussex nursing careers framework in NHS providers • Align Sussex recruitment activity with new national recruitment campaigns • Implement collaborative approach to international recruitment aligned	• Increase nursing clinical placements • Fully embed nursing careers framework in all sectors

	to new national guidance	
Delivering 21st century care	• Implement locallynational changes to medical education content and distribution of trainees developed by HEE (from IPP) • Implement locally *Maximising the Potential* report (SAS doctors) • Implement AHP workforce plan – focus on most challenged specialties • Develop workforce plan for medical staff • Support further maturing of primary care Sussex Training Hub • Implement locally national digital workforce programmes – including training needs assessment with Sussex and action plan	• Develop workforce plan for scientific and technical roles, and other roles • Support full maturation of primary care Sussex Training Hub • Further roll-out digital maturity development plan • Fully streamline induction and on-boarding processes
A new operating model for workforce	• Implement roles and responsibilities for workforce agreed with Regional Team for STP/ICS	• Fully embed ICS workforce responsibilities agreed with Regional Team

8.5. System approach to delivering our workforce priorities

Sussex has a well-established Local Workforce Action Board (LWAB), which is responsible for developing and delivering the workforce strategy for the Sussex Partnership. It is co-chaired by a Trust Chief Executive and Local Director for Health Education England and meets every two months.

At this stage the membership of LWAB is primarily NHS organisations in Sussex, local hospices and Skills for Care. Engagement of local authorities on workforce priorities will develop alongside their wider engagement in the Health and Care Partnership.

The LWAB also oversees the use of external funding for workforce development – primarily from Health Education England and the KSS Leadership Academy.

Strategic priorities for workforce have been agreed by the Partnership Executive Group.

The Directors of Nursing/Directors of Human Resources Group, chaired by the STP Workforce Director and reporting to LWAB, meets each month to progress the strategic priorities agreed by LWAB, and coordinate delivery of the strategy. The membership of this group is Directors of Nursing from NHS organisations and a number of other partner organisations, NHS provider Directors of Human Resources, chair of the AHP Council, and representatives from Health Education England.

Five sub-groups responsible for leading specific strategic priorities and are jointly chaired by a Director of Human Resources and Director of Nursing from a partner organisation:

- Securing Future Workforce Group
- Strategic Workforce Planning Group

- Leadership Development and Talent Management Group
- Best Place to Work Group
- Collaborative Resourcing Group

The SES Training Hub focusses on the primary care workforce, and also reports to the Sussex Primary Care Board. Infrastructure costs for the Training Hub are provided by Health Education England, funding a central team and local training hub teams.

The development of work programmes to deliver strategic priorities is supported by a Sussex Partnership workforce team. This includes a Sussex Workforce Director, who is the senior responsible officer for the programme including coordination of the Partnership workforce strategy, a Strategic Nursing Workforce lead, and project leads who support designated projects.

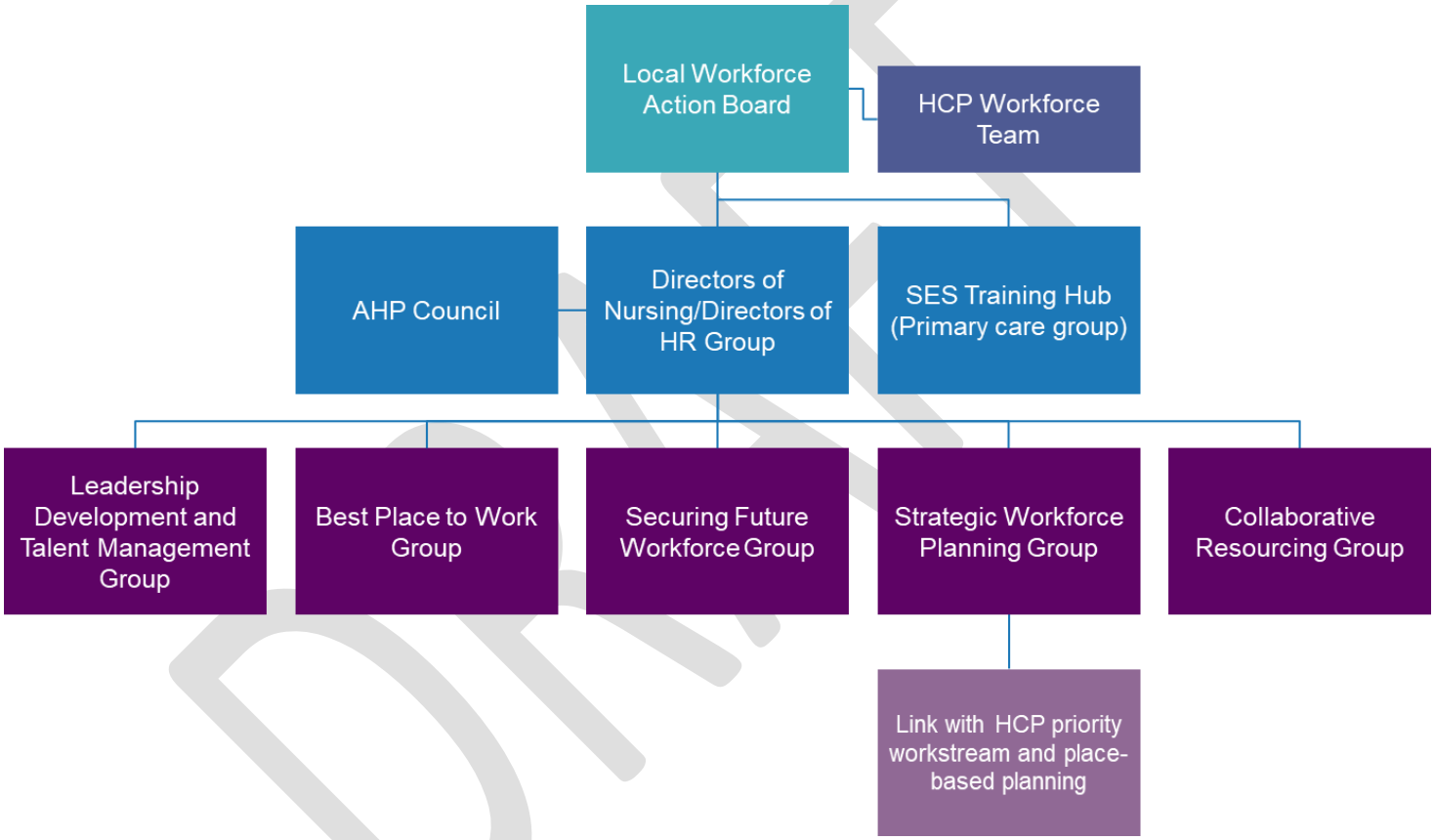


Figure 63: Our workforce programmes

8.6. Key assumptions

The key assumptions for the workforce strategy are:

- Assumptions used in workforce planning are valid for overall projection of future workforce demand and supply.
- Actions planned by Sussex Partnership have the scope to be successful. For example, there is the potential to increase the number of people working in health and care professions to the level described in the plan.
- National/regional funding and support will be sufficient to deliver all aspects of the NHS People Plan, including significant increases in continuing professional development funding

and funding to support increases in clinical placements.

- Further national guidance is provided to the timetable set out in the interim NHS People Plan.

Key workforce risks are provided in section 10.4 on major risks and mitigating actions.

DRAFT

9. Supporting effective delivery: Our Sussex-wide enablers

9.1. Digitally-enabled care

9.1.1. Current state

Governance

The Sussex Health and Care Partnership has placed a strong priority emphasis on rapidly developing the culture and digital maturity of its partner organisations over the past couple of years. Sussex has strong, mature leadership and governance in place with its system and sector-wide Digital Programme Board, which is Chaired by a trust Chief Executive with accountability as Executive Sponsor of the Digital Programme. Reporting into this group are the Sussex Wide Information Governance Group, chaired by the Chair of the National SIGN group, and Design Authorities for developing and maintaining cyber-security, digital standards and shared infrastructure. The newly-established Clinical and Professional Informatics Leaders Forum is bringing together CCIO, CNIO, Clinical Digital Leads and patient representation as a strategic advice group which can advise both the Digital Programme Board and the Clinical & Professional Cabinet, and develop ethical and clinical positions, protocols, and approaches for adoption by the wider Sussex system. We will also collaborate closely with our neighbouring systems during the course of our digital development, including with relation to shared health and care records.

Ambition

Working with clinical and professional leadership and the Partnership Executive team, Sussex has established a clear Digital Ambition which supports the delivery of the Sussex health and care strategic model:

“Seizing the opportunities of digital, data and technology to help our citizens, communities, clinicians and professionals securely redesign our health and care for our future.”

This ambition is underpinned by four key themes, with the outcomes developed and agreed by the Clinical and Professional Cabinet:

- Our Provider’s Digital Maturity
- Our Connected Health and Care System
- Our Digital Services for our Population
- Our Data for Population Health and Research

Sussex has developed and collectively agreed at Digital Programme Board, STP Executive and Clinical Professional Cabinet its initial roadmap through to 2024, and programmes of work including its approach to developing a Local Health and Care Record.

9.1.2. Our Provider’s Digital Maturity

Sussex has a diverse starting position with regards to the digital maturity of its providers, which is acknowledged by partners. Therefore, a key principle of the planning approach over the last two years has been to target investments to close the gaps and unwarranted variation in the maturity of providers so they can all act as strong digital partners in our system. For example, recognising our relative challenge compared with national maturity levels, key clinical priorities, and the variation within our system, we have targeted investments to improve the coverage of Electronic Prescribing

and Electronic Observations, and to converge Order Communications systems to ensure that all providers across Primary, Community and Secondary Care will be able to work seamlessly across our system and to remove workforce barriers to working flexibly across Sussex. Following the recent reorganisation of our Sussex Partnership, the digital maturity of Surrey Heartlands and providers such as SaSH remains important to our system-wide development, therefore we will continue to develop our close relationships with neighbouring systems. The tables below show, first, the collective STP provider digital maturity position in 2016/17 against national rates and, secondly, the variation between providers which informed the prioritisation of investments.

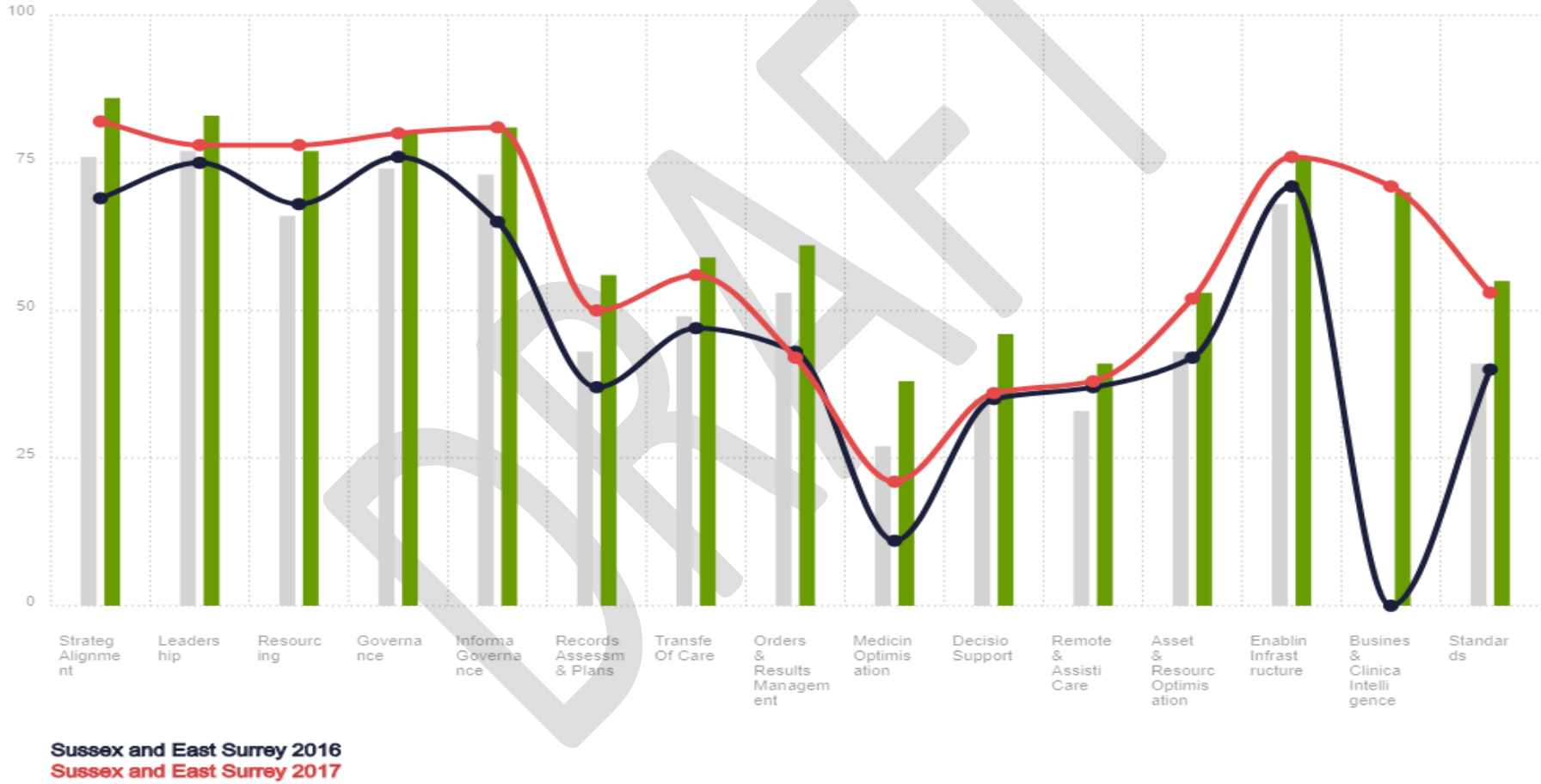


Figure 64: Collective STP provider digital maturity position in 2016/17 against national rates. The grey and green bars are national averages in 2016 and 2017 respectively. Note that Business and Clinical Intelligence Data was not collected in 2016, hence the zero.

DRAFT

Organisation	Strategic Alignment	Leadership	Resourcing	Governance	Information Governance	Records, Assessments & Plans	Orders & Results Management	Transfers Of Care	Medicines Optimisation	Decision Support	Remote & Assistive Care	Asset & Resource Optimisation	Business & Clinical Intelligence	Standards	Enabling Infrastructure
Brighton and Sussex University Hospitals NHS Trust (General)	38	28	50	50	65	35	48	68	17	27	45	45	61	54	78
East Sussex Healthcare NHS Trust (General)	85	81	60	83	62	47	45	53	15	23	15	36	66	31	56
Queen Victoria Hospital NHS Foundation Trust (General)	80	63	85	58	84	27	25	56	8	0	35	40	59	29	61
South East Coast Ambulance Service NHS Foundation Trust (General)	90	89	90	92	90	53	0	56	31	0	0	58	95	43	88
Surrey and Sussex Healthcare NHS Trust (General)	95	94	90	96	97	47	93	70	8	45	60	60	89	67	84
Sussex Community NHS Foundation Trust (General)	80	84	75	79	88	60	16	35	3	64	30	57	45	42	59
Sussex Partnership NHS Foundation Trust (General)	95	94	90	88	94	73	10	36	2	56	69	83	82	75	97
Western Sussex Hospitals NHS Foundation Trust (General)	100	88	90	96	80	62	65	77	74	70	40	50	91	96	89
Sussex & East Surrey Average 2017	83	78	79	80	83	51	38	56	20	36	37	54	74	55	77

Figure 65: Variation in digital maturity of providers

Building upon the strong collaborative culture we have developed as a community, the Digital Programme Board and Clinical and Professional Informatics Leaders Forum have started to focus on developing a digital culture across the workforce and understanding the skills and workforce required for our digital future. Examples of this in practice include the successful 'IG By the Sea' and Sussex Digital Conference events in recent months, and the sharing of good practice business cases and co-production of bids, demonstrating the growing desire and confidence of teams and organisations to work as a digital community of practice and build a shared culture.

Sussex has already achieved reasonable digital maturity in primary care with GP IT services facilitating and recording millions of interactions with patients every week. GP practices have led the way in the move from paper to digital record-keeping and now offer online transactions, such as appointment bookings, repeat prescriptions, and video consultations. The current focused work in supporting improvements in digital maturity for GP practices is on hardening cyber security, Windows 10 deployment, the move to shared cloud storage services and implementing digital dictation, while working to understand the emerging needs of Primary Care Networks and the potential opportunities of a Digital First Primary Care approach. We aim to meet all mandated cyber security standards with 100% compliance across our NHS organisations by summer 2021, as set out in the Strategic Planning tool. Cyber security standards are coordinated through a formal sub-group of the Digital Programme Board. Monitoring and escalation up to Partnership Executive will be used as required, recognising the collective risk posed to Sussex partners and the Health and Care System as a wider community.

9.1.3. Our Connected Health and Care System

Access to integrated information across our system has been identified by clinicians and professionals as a critical challenge, recognising that the lack of it poses a barrier to redesigning services effectively and delivering new models of care at all levels. Significant progress has been made over the past two years, with shared approaches to information governance in support of information sharing now established, and the first place-based shared record access implemented in East and West Sussex across primary, community, mental health, acute and social care settings. These approaches are developing further under the agreed 'Our Connected Care' product developments within our broader 'Our Local Health and Care' programme. In the development of our Digital Ambition, the Clinical and Professional Cabinet clearly identified this as being the most urgent priority for our system. Strong enabling work has been underway across the Urgent and Emergency Care programmes, ensuring that care plans can be shared more effectively, and unlocking access to key information for the ambulance service. Sussex prioritised effective engagement and utilisation of national systems (SCR/AI, CP-IS) before developing its local services, with the result that we have strong access to these in Urgent and Emergency settings and more than double the national average of Frail Patients with SCR AI available.[14]

9.1.4. Our Digital Services for our Population

Developing new digital services for our population has been a key enabler for prevention, a system-wide priority, supporting self-management and the redesign of relationships between clinicians and patients. We are now rolling out our Personal Health Records for patients across our system: this is live in West and East Sussex for outpatients, and moving into supporting the first targeted pathway redesigns in cancer follow-up and diabetes. Sussex has a history of innovation in this area, with the Virtual Fracture Clinic model developed locally and now scaled and implemented within many providers across the country.

In addressing the Urgent and Emergency Care needs of the population, 111 Online has been successfully implemented along with direct appointment booking into our first Urgent Treatment Centres from the 111 service. In Primary Care, Sussex was an early adopter in both the Beta and Live phases of the NHS App, and a targeted Digital First primary care offer is being developed in East Sussex, with the learning being shared with the wider Partnership. Online consultations are also already live and seeing good take-up in East Sussex GP Practices, again with the learning

[14] NHS Digital Data 2019

being shared with wider Sussex partners to inform their offer and deployments, while in the Brighton & Hove and High Weald Lewes Havens areas, TeleHealth for Care Homes pilots are now underway to test and understand the way these offers can be developed and then scaled across the wider system. We will continue to promote the uptake of the NHSApp amongst our population, please see the Strategic Planning tool for more details.

9.1.5. Our Data for Population Health and Research

Sussex is currently developing the Sussex Integrated Dataset, a pseudonymised linked dataset drawn from and supporting all partners in Population Health Intelligence, Research and Analytics. We are working with the support of the team behind the Kent Integrated Dataset, learning from their experience while tailoring the solution for the needs of our service areas. We are also sharing the learning from the experiences at neighbourhood and place-based levels, for example in the Horsham, Mid Sussex and Crawley areas, where neighbourhood level population health management has been well supported with linked dataset and risk stratification, helping target and evaluate services and outcomes effectively for local populations.

Key to our success in learning from experiences is the emerging community of practice around Analytics and Intelligence work, with developing partnerships across Primary Care, Community and Secondary Care, Mental Health, Public Health, local authorities and the police, as well as the support of the Academic Health Science Network and the engagement of academic partners in our local universities.

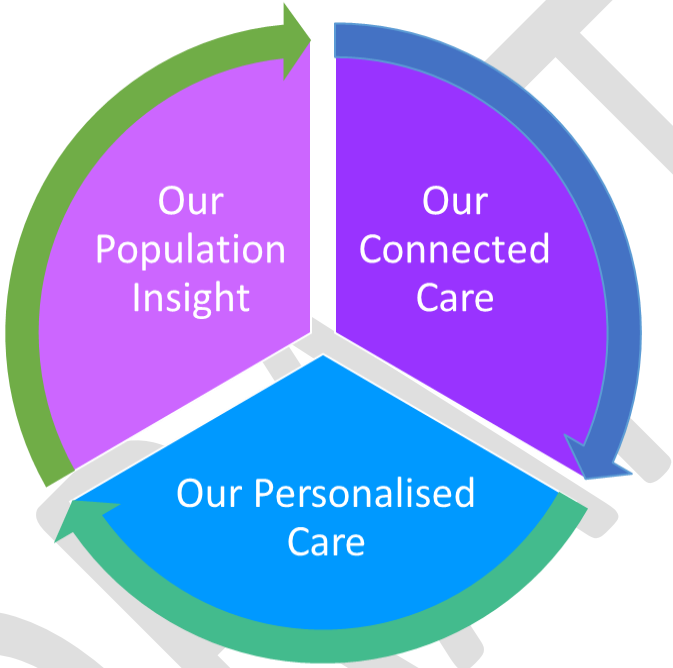


Figure 66: Our digital ambition on a page strongly supports the Sussex Health and Care Strategic Model

Our Local Health & Care - Products



Developing our system capability for population health management, risk stratification, evidence, research, change evaluation and learning



Delivering on the promise of information sharing and enabling communication for the individuals and teams involved in direct care with our population.

Delivering personalised digital health and care services which empower people in self-managing and self-monitoring health and care, enable shared decision making, communication with practitioners, record results and activity and access appropriate care pathways

Figure 67: Key to delivery of the ambition is the development of the three core products for our local health and care

9.1.6. **Digital roadmap**

Our local health and care products are supported by developing the digital maturity of our organisations and their workforce, to be able to act as strong partners in the development of our Sussex Model of Care. Our ambitions and local health and care products are delivered through our digital roadmap which lays out the expected timelines for achieving our commitments.

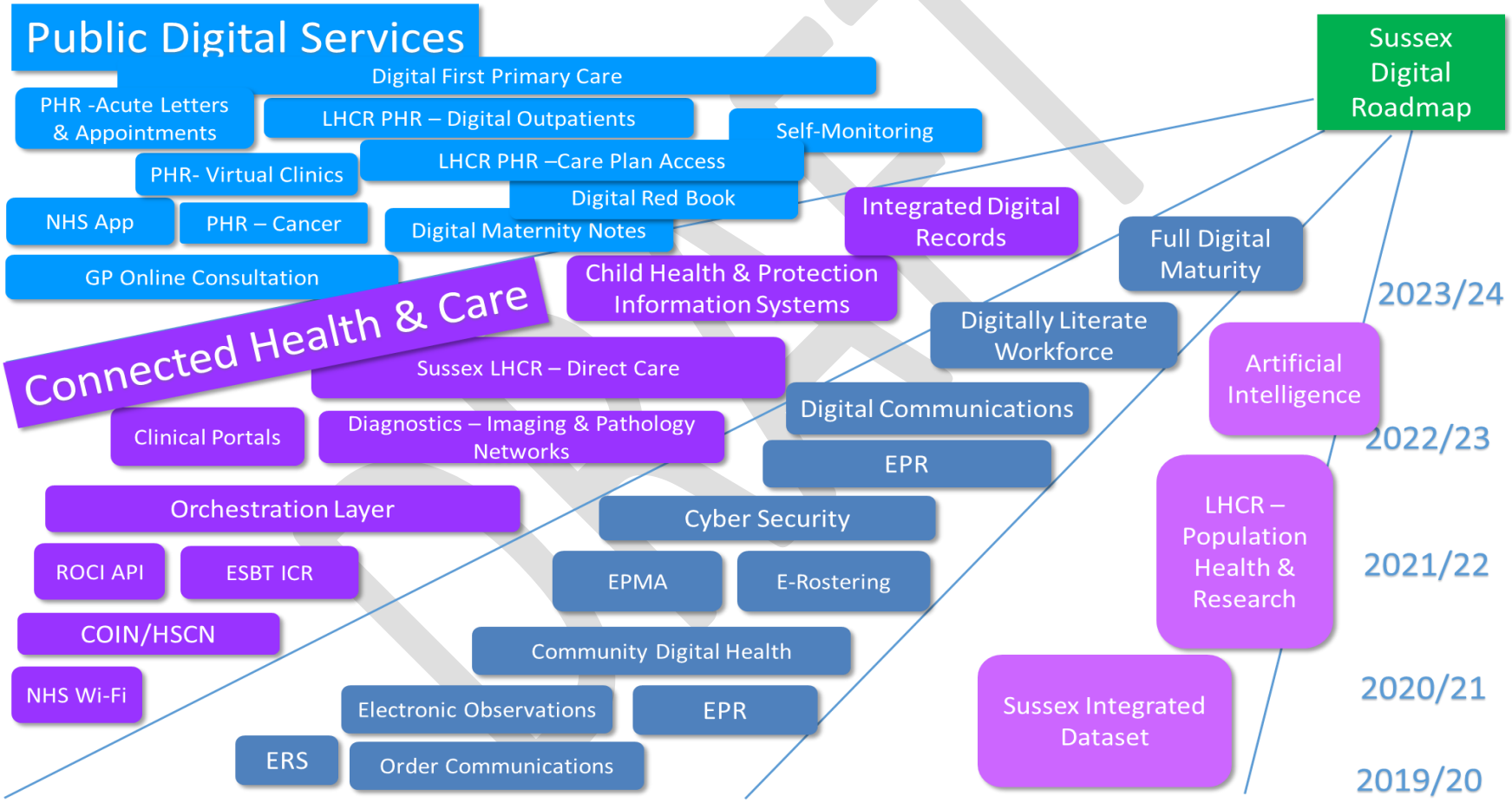


Figure 68: Our digital roadmap

9.1.7. **Our Providers' Digital Maturity**

Our overall ambition is that all partners support each other in growing their individual and collective digital maturity, recognising that, where we let partners lag behind, it harms our collective ability to operate effectively as a digitally-connected system. Partners take responsibility both individually and as part of the wider Sussex system, building upon their strengths and capabilities and sharing the learning to develop blueprints and playbooks for success. Common to providers across all sectors is the collective and individual recognition of the importance of maintaining and continuously improving cyber security postures. Targeted investment is underway to deliver compliance, and to ensure and assure that our collective and individual estate of devices, technical environments, policies, processes and postures are appropriately safe and secure.

Secondary care

All secondary care providers will have reached full digital maturity in line with the assessment standards by 2024, subject to access to adequate investment levels. Strong progress is already being made in achieving digital maturity across providers and Sussex will continue to work collaboratively in prioritising and targeting investments to level-up digital maturity levels and ensure that all providers can work as strong partners to the system.

The following table and diagram summarise the anticipated maturity trajectory for providers over the Long Term Plan period.

Sussex Digital Maturity Trajectory	2019/20	2020/21	2021/22	2022/23	2023/24
SPFT					
ESHT					
SCFT					
BSUH					
WSHT					
QVH					

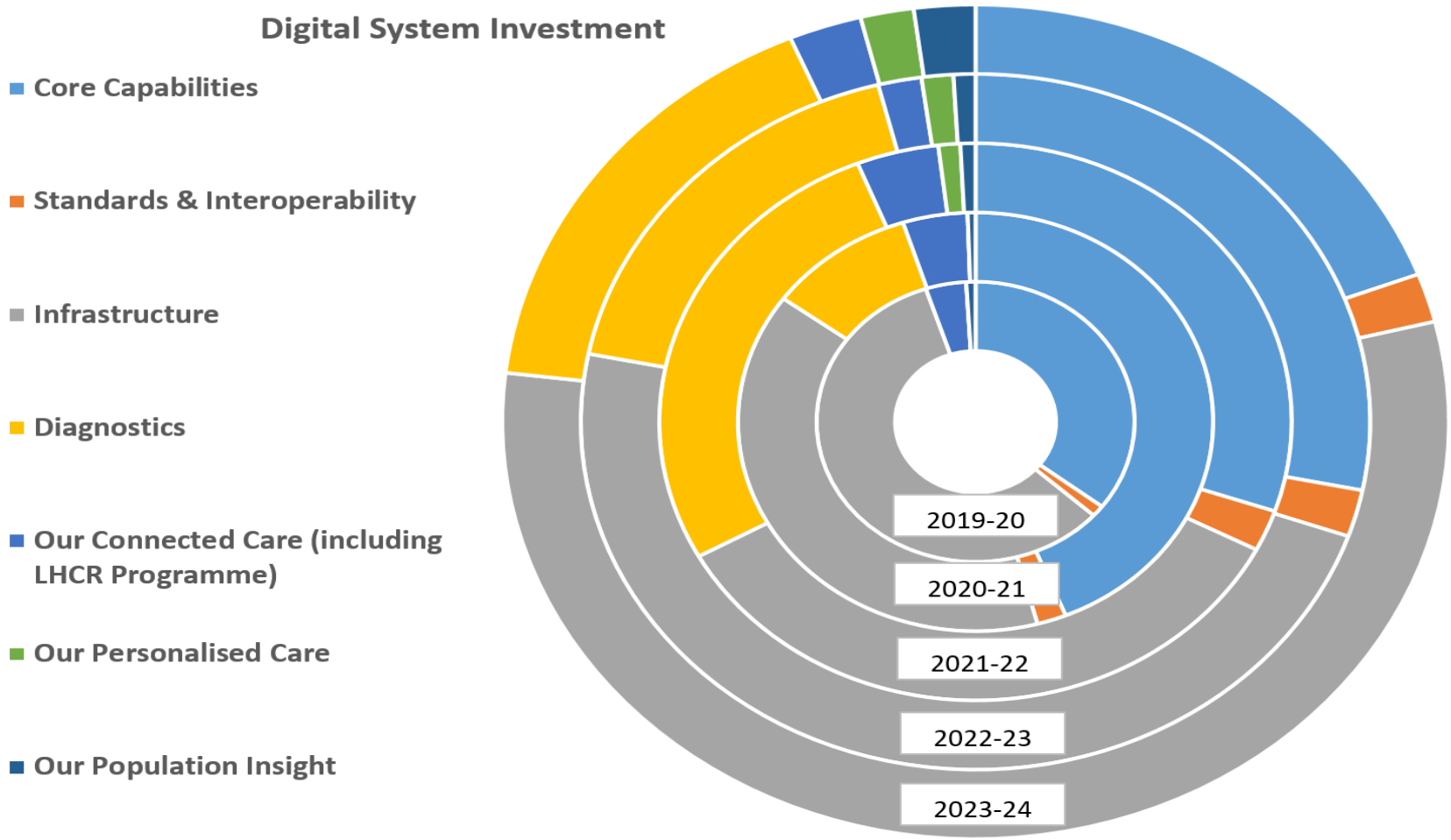


Figure 69: Indicative digital system investment profiles. N.B. this also includes investment for Diagnostics maturity which is not included in the LTP commitment of Full Provider Digital Maturity.

£000's	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total
Core Capabilities	£ 7,526	£ 16,286	£ 11,775	£ 9,441	£ 4,603	£ 49,631
Standards & Interoperability	£ 280	£ 742	£ 930	£ 730	£ 452	£ 3,134
Infrastructure	£ 12,404	£ 14,578	£ 13,403	£ 16,023	£ 13,331	£ 69,739
Diagnostics	£ -	£ 3,735	£ 10,500	£ 6,000	£ 4,000	£ 24,235
Our Connected Care (including LHCR Programme)	£ 877	£ 1,637	£ 1,637	£ 595	£ 595	£ 5,341
Our Personalised Care	£ -	£ -	£ 435	£ 435	£ 435	£ 1,305
Our Population Insight	£ 200	£ 200	£ 300	£ 300	£ 500	£ 1,500
						£ 154,885

Figure 70: Indicative digital system investment profiles

DRAFT

SPFT

The Global Digital Exemplar (GDE) Fast Follower programme is underway, with capabilities to be delivered by 2021, followed by a benefits realisation phase to ensure value is delivered more widely. Infrastructure moving to internet and cloud first architecture/O365, as well as significant growth in trust staffing, will drive core investments in the later phase of the plan. The mental health transformation programme enablement includes integrating mental health services into the urgent and emergency care approach, delivering digital therapeutics as part of the Our Personalised Care approach, while working closely with the wider system to ensure mental and physical health integration is enabled through shared records, common communications and linked data for intelligence.

ESHT

Core capabilities and the Electronic Prescribing and Medicines Administration (EPMA) implementation are underway. Significant investment headlines include the Clinical Portal and Evolve Digital Record roll-out, and upgrade or replacement of PAS from 2021. Significant Diagnostic capability improvements will take place over the period of the Long Term Plan, with PACS replacement in 2020 (with Sussex and Surrey partners) and then movement towards Digital Pathology (2021-22), supporting improvements in Cancer Diagnostics performance and enabling new diagnostic workforce and service models across the partners. Artificial Intelligence (AI), Machine Learning (ML) and Genomics capabilities will start to be introduced in later periods from 2023. Infrastructure will see a continuous move to internet and a cloud-first strategy, with O365 starting in 2020. Outpatient transformation has started, using PHR-enabled pathway redesigns initially in Cancer and Diabetes, then working through other priority pathways using virtual clinic models, patient-initiated follow-ups, self-management/self-monitoring and risk stratified pathways.

SCFT

Core TPP EPR is fully deployed, so SCFT are now moving into digital transformation enabled service redesigns and enhancements across services, also enabled by Office 365 and Business Intelligence capabilities and EPMA implementation in 2020. The needs of integrated staff and services working with Primary Care Networks locally is a key driver, with a focus on information sharing under the Our Local Health and Care programme and pathway redesigns including MSK. Significant estates changes at the Brighton General Hospital site, and a projected growth in trust staffing, mean a clear focus on mobility of workforce, using digital services to enable co-designed services with patients and service users, and improving the user experience for staff in delivering services. Service redesigns will incorporate new digital services for referral, self-referral and transfers of care, and deliver patient-facing PHR-enabled services through involvement in system-wide and trust pathway redesigns.

BSUH

EPMA is an immediate priority alongside maternity system replacement following ESHT's initial implementation. Clinical Portal developments support Connected Care LHCR transformations and Transfers of Care. There will be significant diagnostic capability improvements over the period of the Long Term Plan, with PACS replacement in 2020 (with Sussex and Surrey partners), LIMS Replacement through to 2022, and then moves to Digital Pathology (2023-24) supporting improvements in Cancer Diagnostics performance and enabling new diagnostic workforce and service models across the partners. AI, ML and Genomics capabilities start to be introduced in later periods from 2023. Outpatient transformation has started, using PHR-enabled pathway redesigns, initially targeting Opthamology then working through other priority pathways using virtual clinic models, patient-initiated follow-ups, self-management/self-monitoring and risk stratified pathways.

WSHT

PAS replacement is the critical priority starting in 2020. Clinical Portal developments support Connected Care LHCR transformations and Transfers of Care. There will be significant diagnostic capability improvements over the period of the Long Term Plan with PACS replacement in 2020 (with Sussex and Surrey partners), LIMS Replacement through to 2022 and then moves to Digital Pathology (2023-24), supporting improvements in cancer diagnostics performance and enabling new diagnostic workforce and service models across the partners. AI, ML and Genomics capabilities will start to be introduced in later periods from 2023. Outpatient transformation has started, using PHR-enabled pathway redesigns, initially targeting Gastroentorology then working through other priority pathways using virtual clinic models, patient-initiated follow-ups, self-management/self-monitoring and risk stratified pathways.

QVH

e-Observations is the immediate priority for QVH, followed by EPMA in 2020. Significant Diagnostic capability improvements will occur over the period of the Long Term Plan, with PACS replacement in 2020 (with Sussex and Surrey partners), LIMS Replacement through to 2022 and then moves to Digital Pathology (2023-24), supporting improvements in cancer diagnostics performance and enabling new diagnostic workforce and service models across the partners. QVH will continue to develop digital planning and delivery of surgery using CADCAM, VR and 3D printing in maxilo-facial and breast reconstructions.

SeCamb

The immediate priority is the mobilisation of the new 111 and Clinical Assessment services, delivery of core mandated requirements, and integrating with wider systems, including Mental Health and the transformations in the Urgent and Emergency Care system. Key digital enablers of these changes are completing the roll-out of Cleric EPR, and its access by, and then integration with, acute trusts for improvement in handover of conveyed patients to A&E. Medium term improvements will see delivery of a Trust Integration Service to ensure standardised methods of interacting with the developing local LHCRs across Kent, Surrey and Sussex, using nationally and locally mandated standards.

The investment requirements in most trusts are reliant on significant external investment support to achieve full digital maturity within the Long Term Plan period. The system is ready to work closely with NHS England & Improvement and NHS X to agree and shape the investment trajectories in support of the transformation priorities of the Sussex Health and Care Partnership.

DRAFT

9.1.8. Primary Care

Digital maturity levels are already reasonable across Primary Care within Sussex and there will be a strong focus on supporting GP Practices and Primary Care Networks (PCNs) to leverage the opportunities to shape their service offers using digital channels and to become Digital First practices and PCNs. This will include harnessing the opportunities provided by the new GP IT Futures programme over the coming years. Key to success in meeting the developing the Digital First offer in primary care will be recognising the challenging capacity demands, expectations of patients and complexity, while looking to the opportunities that new roles and offers in Primary Care Networks such as First Contact Practitioners (FCPs) will require. The Sussex Health and Care Partnership has started on this journey through our early transformation programme approaches across Unwarranted Clinical Variation and Urgent and Emergency Care. Our Local Health and Care programme has agreed MSK as one of its initial clinical priority areas, with the digital needs of staff a critical enabler of the changes being introduced. Sussex has strong experience to learn from in piloting FCP models and will work closely with Accelerator PCNs to understand their user needs and provide targeted digital offers for them. As an example, Physiotherapists and patients in MSK services locally have co-designed and developed a digital offer – MSK Assist, working with national innovation investment and support from the AHSN. Our co-design approach to understanding and then shaping our Digital First offerings, understanding and responding to the needs of patients, practices and pathways will help us evolve our Digital First offerings in primary care based in population needs.

9.1.9. Infrastructure

Our providers will take a collaborative approach to infrastructure, ensuring that existing investments deliver their necessary returns while seeking economies within the Sussex system by offering services to other providers or the wider system. At investment renewal points, providers will shift their hosting and infrastructure services towards internet first and public cloud models, using hybrid approaches and taking the learning from each other, while ensuring that they maximise the return on existing investments.

Where new digital services (including the LHCR products) are developed, they are defaulting to internet-first and public cloud offerings, for example the Orchestration Layer and Sussex Integrated Dataset are being hosted within Microsoft Azure. The community will leverage the opportunity in these shared environments and new services to develop its workforce skills, capability and capacity, recognising that there are significant new skillsets required for engineering in these environments, but also acknowledging that adopting common industry standards and approaches will help with recruitment and retention. Primary Care is mirroring this approach for shared and common services, which are defaulting to cloud offerings.

9.1.10. Skills and culture

Sussex is developing a strong collaborative Digital Culture, and will work over the coming year with the SHCP Workforce programme, local authorities, Local Enterprise Partnerships and through the Our Local Health and Care programme to develop its leadership and workforce plans. This will include defining and implementing the approach to Digital Leadership, establishing CIO/CCIO roles on the Boards of organisations, and planning for the medium term digital needs of the wider workforce and the specific skills and capabilities required, being mindful of the Topol Review findings and the Interim NHS People Plan. The first phase of this will start in 2020, to baseline the current position and establish the immediate workforce priorities. We will use the lessons we learn

through the ‘Our Local Health and Care’ programme to help shape the workforce skills approaches and share them widely across the system.

9.1.11. Our Connected Health and Care System

Our Connected Care Products are a key product development in the ‘Our Local Health and Care Connected programme’.

Sussex has defined its initial programme of work to improve the interoperability and integration of systems and partners across Sussex through the Our Local Health and Care programme. This will deliver three key product areas in line with the requirements of the Local Health and Care Record requirements. Sussex’s approach is to enable clinical priority transformation programmes while delivering exemplar digital services at all geographical levels of our new Sussex Health and Care Strategic Model – neighbourhood, place and system.

The initial clinical priorities identified are MSK and Falls & Fragility, as part of the Unwarranted Clinical Variation programme, and Mental Health, with secondary priorities of Cancer and Diabetes for which we will deliver targeted support. We will work over the first half of the Long Term Plan period to deliver these exemplars and an effective playbook and blueprints for scaling roll-out through the second half of the Long Term Plan period of these services across all clinicians, professionals and communities. We are embedding user-led design approaches into the digital services we will offer and are using the transformation programme to develop the clinical and professional workforce skills, capability and culture to leave a sustainable legacy for continuous quality improvement.

Sussex’s Our Connected Care product architecture and technology approach is to build on our existing Beta Orchestration Layer products and local development capabilities and successes, using industry standard public cloud hosted and internet-first architecture in line with national design principles. By building out from existing systems we will minimise disruption for users and can deliver user-led, locally designed and developed products aligned to developing national and industry standards including Care Connect apis and FHIR. This approach has already delivered the Integrated Care Record in East Sussex, bringing together a single user experience launched from users’ regular line of business systems – using an initial registry of real-time data apis from GP records, Community, Acute, Mental Health and Social Care to support our developing integrated care teams and their new models of care delivery. The approach is supported by a Sussex-wide approach to information sharing, enabled by the Information Sharing Gateway.

DRAFT

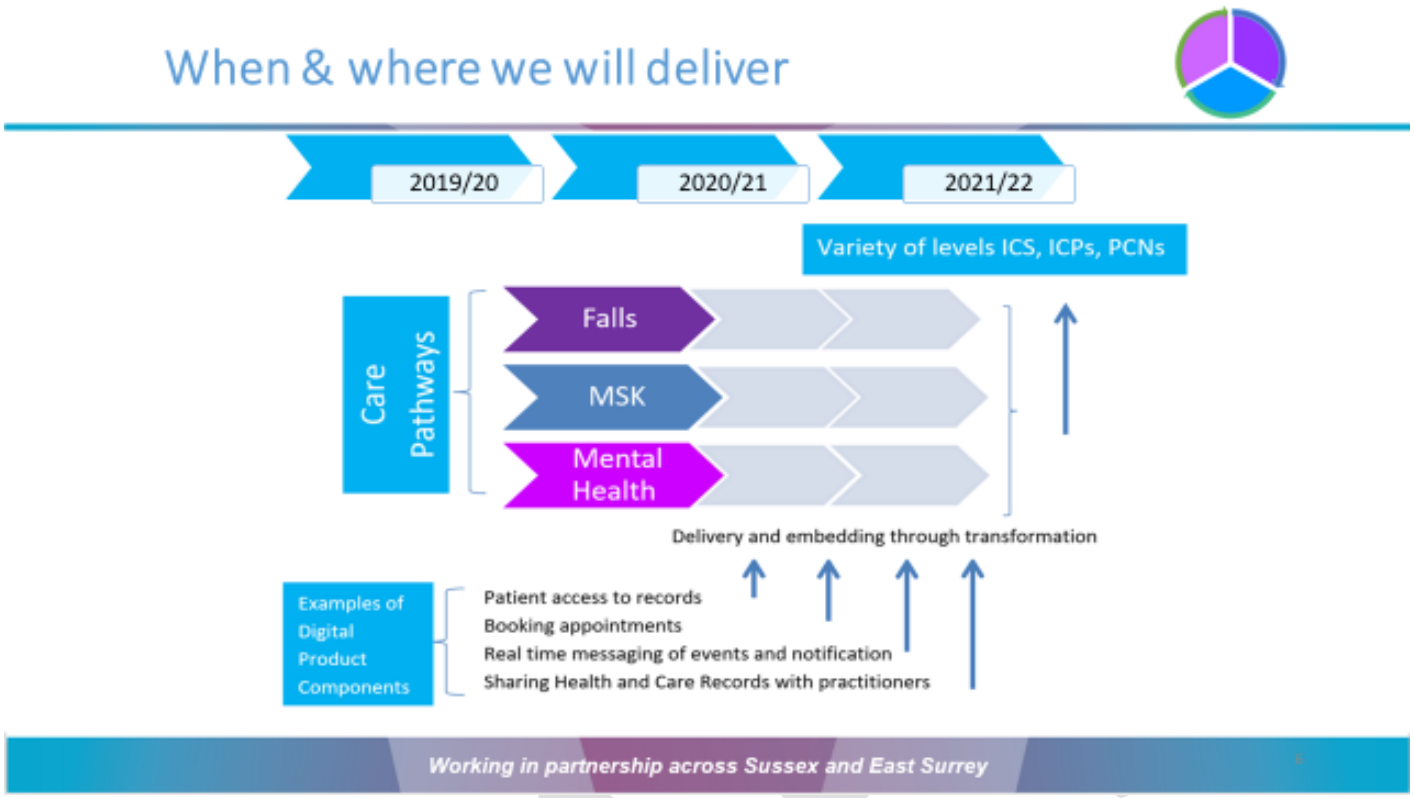


Figure 71: When and where we will deliver

Diagnostics

Our existing Order Communications investments are joining up the order and resulting of diagnostic testing across Sussex, with interoperability across sectors and geographies, which will be fully delivered by the end of 2019/20. Sussex already has a shared diagnostic imaging partnership in place, covering Sussex and Surrey and common, interoperable PACS, RIS and VNA, although not all of the benefits of the original vision have been achieved to date. There is an active re-procurement underway which will see a move to a common cloud-based model, taking advantage of the architectural advances since the previous procurement while ensuring that the standards-based approaches are maintained and enhanced.

There is immediate pressure to ensure that the Diagnostics vision supports the advances in and demands for rapid diagnostics for Cancer services and wider pathways – including adoption and implementation of digital pathology across providers and the links out to genomic testing service remotely. Following the re-procurement and migration, Sussex will use this revived Diagnostic network to seize the opportunities for Artificial Intelligence (AI) and Machine Learning (ML) to support improvements in this area. It is clear from the workforce and emerging demand projections across diagnostics areas that diagnostics could form a supply blocker to clinical and quality improvement if it were to be held back by technology. The implementation of the cross-trust and agile reporting vision will bring together the wider workforce's collective capacity, already embraced in Sussex, and offer the opportunity to further explore AI based automation in reporting.

9.1.12. Our Digital Services for our Population

Our Personalised Care Products are a key product development in the 'Our Local Health and Care programme'.

We are actively rolling out Personal Health Records (PHRs), supporting the place-based and system-wide outpatient transformation ambitions not just to reduce outpatient appointments by a third, but more importantly to transform the experience of patients in this crucial area, offering digital services which match the raised expectations of patients in our digital age. Initially, this will deliver core functions including access to letters, appointments and results for patients, while providing messaging, care/treatment plan and video consultation options.

Building on our experience developing and delivering successful virtual clinics and digital offerings in fracture clinics, IBD and HIV services, we will enable the digital transformation of the outpatient pathways, including by providing support for the place-based targeted redesigns for gastroenterology and other emerging priorities, and offering virtual clinics, patient-initiated pathways, and self-management and self-monitoring support.

We are already developing the PHR-based Personalised Care Product offerings for risk stratified Cancer follow-ups in Breast, Colorectal and Prostate which, following successful tests in the system, will be expanded to all parts of Sussex over the plan period. We are also enabling the UCV clinical programmes – MSK, Falls, CVD and Diabetes – where we will target digital offerings co-designed with our patients, clinicians and practitioners, ensuring we develop the learning and evidence development. These will work through the whole pathway, from prevention through primary care and into long term condition management, bringing together primary, community, mental health and secondary care provider offerings. Alongside this, we will build on and further develop the work in Mental Health on both Digital Therapeutics and digital service offerings which meet service users' needs and growing expectations. Our strong academic relationships will help us ensure that the evidence-based effectiveness of these approaches is at the heart of our innovation and development. We will deliver across these pathway areas over the first two years and subsequently expand the cohort of patients covered to include new pathways and conditions, ensuring consistent Sussex-wide coverage.

Our ambition is to be able to offer Personalised Care Products to all outpatients and most long term condition patients, recognising that the rapid demographic growth and health economic cost of supporting this population is one of the most critical challenges our Population Health Check identifies. Developing this digital relationship with patients will enable us to better support them in self-managing, self-monitoring and reducing the escalations of care that otherwise develop. We will continue to build our evidence base of approaches that work for cohorts and population groups and enable best possible value to the health economy.

In Primary Care, we will have a Digital First comprehensive offer of online consultations and triage, including video-based consultation, redesigning these to work with the developing new pathways across Urgent and Planned Care. We recognise that GP practices will adopt and develop at different paces due to their local population demand, practice culture and the challenges they are facing. We will support all GP Practices in offering a comprehensive Digital First package for patients, drawing on our initial user-led co-design in East Sussex and the innovation and digital services developed locally across our system. For example, we will develop the already well-regarded social prescribing offers from place and neighbourhoods by supporting them with strong digital offerings. There is an innovative current example in Adur & Worthing, where the digital offer

has been co-designed and developed with the local authority on their low-code platform, using their Same Room user-led design approach to meet the needs of citizens, clinicians and communities.

We recognise the commitment to offer a Digital Primary Care service as a complement to local list-based GP Practice approaches and will work with our local community of GP Practices, Primary Care Networks and the wider system to co-design with our population offers that sustainably deliver quality services for those patients. Given the demand pressures on Primary Care services and the challenge of maintaining the sustainability of GP services for the population, particularly in areas of high deprivation, delivery of Digital First and Digital Only services may provide important opportunities. However, in keeping with our broader approach, we work to understand the user needs of our population and the evidence of the impact and effectiveness of these service models.

9.1.13. Our Data for Population Health and Research

Our Population Insight Products are a key product development in the 'Our Local Health and Care programme'.

We will continue to develop Our Population Insight products including the Sussex Integrated Dataset (our cloud hosted, pseudonymised, linked data platform), to incorporate ever richer and wider datasets. This will provide evaluation and assurance in the development of the Sussex Model of Care, the move to be a self-assuring ICS, and meeting the population health intelligence needs of ICPs and PCN. We will develop targeted offers to help the developing PCN understand in new rich ways the profiles and needs of their neighbourhood populations, and use risk stratification and case finding approaches, drawing on the ever more sophisticated data to predict and identify patients and populations who can benefit from intervention and support. In keeping with our wider approach, we will build on the local learning achieved across Sussex, including the work in Horsham, Mid Sussex & Crawley using population health management and risk stratification approaches to shape their local community understanding and emergent Primary Care Network services for individuals who are approaching end of life; and the work in Brighton & Hove analysing the significant impact on the wider health and care economy of multiple long term conditions in contrast to frailty measures.

We will create the environment for clinical development of new predictive approaches, building on existing strong relationships with Universities (which include SPFT, BSUH, BSMS and Sussex & Brighton Universities and the newly agreed Applied Research Collaborative across Kent Surrey and Sussex, hosted by SPFT). We will also begin to test and evaluate the effectiveness of new clinical and population health AI approaches. For example the national review of AI & ML in Healthcare in the UK written by DHSC and KSS AHSN highlighted the ASTRODEM project, where local academic researchers working in a cross disciplinary team across primary care, astrophysics and data science have developed AI models for early diagnosis of dementia. The SID will offer a new environment to bring research initiatives into real-world practice and enable the longitudinal evaluation of these models in partnership with academic colleagues and the AHSN.

We will work to develop new workforce skills, capabilities and pathways to ensure our analytics, intelligence and data science skillsets are embedded in clinical and professional development, and that we have understood both the opportunities and needs which Professor Topol's review identifies.

AI and ML will also play a crucial role in developing our system-wide approaches to the demands on diagnostic capacity and capability, as the changing demographic profile and advances in

diagnostic requirements place ever greater demand on an already challenged workforce. We will build on our networked imaging and other diagnostic capabilities, following our migration to a new cloud-hosted service, to then start training and applying AI in imaging, testing and understanding the complex clinical pathway and safety redesigns needed to confidently adopt these approaches while maintaining and enhancing quality.

Importantly, we will continue to build on our effective system-wide approach to operational pressures management in Urgent & Emergency Care using the SHREWD service. This approach to using clear common, visualisations of agreed up-to-date data to improve real-time system decision making has proven effective. We will move on to examine how we can start to incorporate, evaluate and operationalise projection and predictive measures into this area, drawn both from existing health and care data patterns, but also considering how wider measures may effect things from weather projection to emerging social intelligence, for example in flu outbreaks.

DRAFT

9.1.14. Sussex system digital investments

Sussex Digital Investment Profile		Year 1		Year 2		Year 3		Year 4		Year 5			
		C	R	C	R	C	R	C	R	C	R	Total	
	Digital Investment	2019-2020	2019-2020	2020-2021	2020-2021	2021-2022	2021-2022	2022-2023	2022-2023	2023-2024	2023-2024	C	R
SPFT	**Core Capabilities**	**1468**	**430**	**988**	**540**	**485**	**540**	**485**	**540**	**485**	**540**	**£3,911**	**£2,530**
	Standards & Interoperability	**105**	**0**	**222**	**0**	**275**	**50**	**175**	**50**	**97**	**50**	**£874**	**£150**
	Infrastructure	**3169**	**250**	**3758**	**250**	**2663**	**250**	**5663**	**250**	**2891**	**250**	**£18,144**	**£1,250**
ESHT	**Core Capabilities**	**1468**	**30**	**2655**	**440**	**1360**	**290**	**1720**	**40**	**260**	**40**	**£7,463**	**£840**
	Standards & Interoperability		**100**	**200**	**100**	**330**	**100**	**230**	**100**	**30**	**100**	**£790**	**£500**
	Infrastructure	**1585**		**2420**		**2690**		**2610**		**1690**		**£10,995**	
	Diagnostics			**1060**		**1000**						**£2,060**	
SCFT	**Core Capabilities**	**1400**		**2448**	**481**	**2500**	**210**	**2500**	**210**	**2283**	**210**	**£11,131**	**£1,111**
	Standards & Interoperability	**75**		**120**		**150**		**150**		**150**		**£645**	**£0**

	Infrastructure	1400		2100		1300		1500		2500		£8,800	
BSUH	Core Capabilities	2000		2367		800		450		250		£5,867	£0
	Standards & Interoperability											£0	£0
	Infrastructure	3000		3000		3000		3000		3000		£15,000	
	Diagnostics			1300		4500		3000		2000		£10,800	
WSHT	Core Capabilities	100		3642		3675		2971		150		£10,538	£0
	Standards & Interoperability											£0	£0
	Infrastructure	3000		3000		3000		3000		3000		£15,000	
	Diagnostics			1300		4500		3000		2000		£10,800	
QVH	Core Capabilities	260	370	725	435	760		200		100		£2,045	£805
	Standards & Interoperability											£0	£0
	Infrastructure			50		500						£550	
	Diagnostics			75		500						£575	
SeCamb	Core Capabilities			1565		1155		325		285		£3,330	
	Standards &			100		25		25		25		£175	

DRAFT

	Interoperability												
Sussex System	**Our Connected Care (including LHCR Programme)**		**877**		**1637**		**1637**		**595**		**595**		**£5,341**
	Our Personalised Care						**435**		**435**		**435**	**£0**	**£1,305**
	Our Population Insight		**200**		**200**		**300**		**300**		**500**	**£0**	**£1,500**
Total		**19030**	**2257**	**33095**	**4083**	**35168**	**3812**	**31004**	**2520**	**21196**	**2720**	**£139,493**	**£15,332**

Figure 72: Our digital investments

DRAFT

9.2. Estates

9.2.1. Current overview

The system partnership has worked collaboratively to ensure that the Estates Strategy responds to and supports the need of the local population and the Sussex Health and Care Plan.

The initial Sussex and East Surrey STP Estates Strategy was developed in July 2018. This was assessed by NHS England and Improvement (NHSE/I) and given an overall banding of "improving". Significant progress has been made to further develop and deliver the Estates Strategy and this has been reflected in the Sussex and East Surrey STP Estates Strategy Checkpoint document, which was submitted in mid July 2019. A summary of investments and capital priorities can be found in Appendix H.

The Checkpoint submission includes detailed updates on:

- 2018 Estates Strategy Feedback and system response
- Estates governance
- Clinical service strategies and capital plans
- Primary care estates strategies and capital plans
- Disposal plans for surplus land and buildings
- Estates efficiencies
- Delivery of STP Wave 1-4 capital projects
- Delivery plan
- All capital projects across the system.

Re-assessment of this document by NHSE/I is complete. We have been advised that a recommendation for re-banding of the Estates Strategy from "improving" to "good" has been made to the NHS Property Board. A formal outcome is anticipated in November.

This re-banding is a prerequisite for the approval of all STP Wave 3 and 4 capital business cases.

9.2.2. Estates priority delivery areas

The Estates Strategy has been developed around two key themes. Each theme includes a set of strategic objectives which are aligned to national and local priorities within the Five Year Forward View, the Long Term Plan and the Sussex Health and Care Plan:

1. Transforming models of care

    - Out of hospital care including One Public Estate
    - Urgent and emergency care services
    - Mental health case for change
    - Construction of the BSUH 3T's
    - Clinical service development and modernisation

2. Keeping the estate safe and fit for purpose

    - Reduce high and significant backlog maintenance
    - Make the estate more efficient
    - Shared services

Transforming Models of Care

Out of hospital care

Primary care services will be delivered at scale with co-location and cooperation of practices within Primary Care Networks. The primary and community estate will be planned and managed to support the development of integrated community hubs. These hubs will deliver primary, community, mental health and out of hospital services, catering for the health and care needs of the local populations. Where possible, services will be expanded to include community-based maternity hubs, rapid diagnostics for cancer, and health, wellbeing and prevention services.

The total investment requirement to deliver this vision is circa £373 million. This includes a comprehensive configuration of area and local health hubs supported by primary care spokes across Sussex. The list of anticipated integrated hubs and primary care spokes is included within the Estates Strategy Checkpoint document in section 4.

Work is ongoing to develop the Primary Care Estates Strategy in response to the Primary Care Strategy. Detailed analysis of existing primary care infrastructure, including condition, functionality and capacity, has been undertaken. Further work is in development to understand the impact of multi-morbidity at PCN level, population and housing growth, demographics, deprivation, and social care need. It is anticipated that this strategy will be complete in early 2020.

Urgent and emergency care

The investment requirement to deliver the estates element of the Urgent and Emergency Care Programme is circa £48 million. This includes the delivery of urgent treatment centres, co-located with the acute provider emergency departments, minor injury units and extended access hubs; new diagnostic equipment including MRI scanners; and the development of “make ready centres” for the ambulance service. The two “make ready centres” have secured DH FBC approval as part of the STP Wave 4 capital bidding process and construction is due to commence shortly.

Funding is required to deliver plans for the UTC’s at Worthing, Eastbourne and Conquest hospitals, having been unsuccessful in the previous STP capital bidding round.

Mental health case for change

Specialist inpatient centres to transform the delivery of adult acute and dementia care are in development in West and East Sussex. A complex transformation programme is underway which includes the relocation, reconfiguration, replacement and disposal of unfit/surplus estate, and the co-location of community mental health services into integrated community hubs. Public consultation is required in relation to significant service change.

There is an investment requirement of circa £130 million to deliver this transformation programme. Part of this investment will be funded from within the providers’ capital resource limit and part from their disposals programme. There is likely to be a funding shortfall.

Construction of the BSUH 3T’s

The Teaching, Trauma and Tertiary care (3Ts) programme is a £485 million redevelopment of the Royal Sussex County Hospital, scheduled for completion in 2024/25. Funded from public capital supported by a Treasury approved FBC, the programme will be delivered in three phases over nine years and will replace 50% of the trust’s ageing estate on the Royal Sussex County Hospital in two new buildings accommodating more than forty wards and departments. The new accommodation will provide the highest standards of clinical functionality and patient environment. This programme supports the accelerated transformation of old estate to meet the demands of the modern health service.

In addition to the £485m project costs, the FBC assumed a further £26 million funding from alternative sources. This funding has now been secured following extensive discussions with NHSE/I.

Clinical service development and modernisation

There are several significant clinical service development schemes requiring investment funding to deliver the estates solution. Providers are working collaboratively to meet the national requirement for all pathology services in England to be part of a pathology network by 2021. The system has secured STP Wave 3 capital funding of £19.3 million, subject to approval of business cases, to support the integration of pathology services across three provider trusts.

In terms of estates modernisation, the system has a high level of critical backlog maintenance and compliance issues. This has resulted from a historic lack of investment over many years by previous system leaders. There is a requirement for fire compartmentation works at Eastbourne hospital to meet statutory fire regulations, and the value of these works is circa £13.9 million. A bid for STP Wave 4 capital was unsuccessful and a further bid was submitted to NHSE/I for emergency backlog maintenance funding, which has very recently been approved.

The total investment requirement for this strategic objective is circa £155 million.

Keeping the estate safe and fit for purpose

This aim includes reducing the high and significant backlog maintenance, making the estate more efficient and managing shared services.

Provider trusts are working collaboratively to deliver operational estates efficiencies to meet the national Carter targets. These targets include efficiencies around estates running costs, percentage of non-clinical space, unoccupied floor space, total backlog maintenance and critical infrastructure risk backlog maintenance.

In terms of estate running costs the system performs well against national benchmarks. The provider trust median is £35.46 per sqm less than the national benchmark and the number of estates running costs has reduced from July 2018. Providers are planning to reduce this further by 2020/21.

There is a requirement within the LTP for all providers to reduce their amounts of non-clinical space by a further 5%, freeing up over one million square metres of space for clinical or other activity. As indicated in the table below, the providers have reduced the percentage of non-clinical space to 24%, which is 11% below the Carter target of 35%. Whilst this reduction is significantly smaller than the national benchmark, providers will continue to work to reduce this percentage further.,

Total backlog maintenance and critical infrastructure risk is likely to increase during 2019/20 as the outputs from six facet surveys carried out at ESHT and BSUH are realised. Western Sussex Hospitals has commenced a trust-wide programme to significantly reduce backlog maintenance and critical infrastructure risk over the next five years and a similar approach may need to be adopted by other providers.

The total investment requirement for these three strategic objectives is circa £62.9 million, with £56.4 million allocated to delivering high and significant backlog maintenance projects across the system.

A detailed summary of progress against the estate efficiency targets is set out in the following table.

Indicator	Baseline 2017/2018 position	Forecast target position for 2020/2021 (17/18 prices)	Progress against targets
Estate Running Costs pa Estate Running Costs £/m2 (median)	**£205.9 m** **£324.54**	**£202.5 m** **£315.00**	Benchmarked against NHSI Carter/ERIC 2017/18 E&F data analysis of £360 per m2 - Trust median is £35.46 per m2 less than national benchmark Reduction in total estates running costs from July 2018 Strategy of £21.87 per m2 and £23.4m per annum
Non-Clinical Space m^2 Non-Clinical Space % (Carter target 35%)	**190,425** **24%**	**220,134** **24%**	Benchmarked against NHSI Carter/ERIC 2017/18 E&F data analysis of 33.9% for non clinical space – Trust median is £9.9% less than national benchmark Reduction in non clinical space from July 2018 Strategy of 5.2% To note: ESHT: 6 facet survey due in July 2019, significant increase predicted.
Unoccupied Floor Space m^2 Unoccupied Floor Space % (Carter target 2.5%)	**17,165** **2.3%**	**14,918** **1.6%**	Reduction in unoccupied floor space from July 2018 Strategy of 0.7% SFT: Service improvements are expected to increase the use of clinical space
Total Backlog maintenance (£)	**£146.7 m**	**£148.1 m**	ESHT: 6 facet survey due in July 2019, significant increase predicted and unlikely to reduce without significant external capex investment. WSFT: A corporate project has commenced with a commitment to significantly reduce backlog and critical infrastructure risk over the next 5 years. BSUH: 6 facet survey being undertaken. SASH: Complete review underway.
Critical Infrastructure Risk (CIR) Backlog Maintenance (£)	**£59.2 m**	**£72.9 m**	

Figure 73: Progress against estates efficiency targets

9.2.3. Sustainability

Providers are working collaboratively to progress energy efficiency and environmental sustainability initiatives across the estate. Specific projects include:

- **System-wide EPC project:** Procurement of new energy infrastructure and services for six of the Sussex and East Surrey providers through an ESCo arrangement delivered through the Carbon and Energy Fund Framework. Net savings of £15.7 million over 15 years have been identified alongside significant reductions in carbon emissions. The invitation to tender is in the process of being released to the shortlisted bidders following a series of technical meetings over the last few months. Construction is due to begin in March-May 2020.

- **Joint waste tender:** Delivered across four trusts for healthcare and non-healthcare waste. The project will deliver financial savings (level still to be determined) and waste targets across the trusts to meet zero waste to landfill and 75% recycling targets.

- **Care Without Carbon SDMP**: Integrated across four trusts, delivering savings and carbon reductions in line with the Climate Change Act and NHS Long Term Plan.

9.2.4. Prioritised capital programme

The capital programme included with the Estates Strategy Checkpoint document includes all investment projects for Sussex and East Surrey. East Surrey has since transferred to the Surrey STP/ICS and this has necessitated a refresh of the capital programme and prioritisation process.

The programme has been further developed, assessed and prioritised by key stakeholders from across all Sussex NHS organisations. It reflects the ambitions of the system to deliver the key priorities within the Sussex Health and Care Plan.

The programme has been divided into two sections:

- Section one includes all system strategic investment projects in priority order, regardless of funding, total value £742 million (all projects over £500,000 value)
- Section two includes those system strategic investments that require capital funding (PDC), in priority order, total value £345 million.

A schedule of the updated Sussex prioritised system strategic investment projects and prioritised capital projects can be found in Appendix H.

A summary of the 21 system-wide schemes prioritised for capital expenditure is set out in the table below:

Strategic Ranking	Capital Ranking	Project Title	Organisation	Project Value (£000's)	Delivery Year
4	1	Eastbourne UTC	ESHT	3,800	21/22
5	2	Conquest UTC – Development of Single Assessment Unit	ESHT	6,500	21/22
6	3	Worthing UTC	WSFT	13,200	21/22
8	4	Crawley Hospital	Crawley CCG	125,000	23/24
9	5	Littlehampton Primary and Community Hub	CWS CCG	15,000	23/24
10	6	East Sussex Bed Reconfiguration	SPFT	70,000	23/24
12	7	Acute reconfiguration to enable SPFT bed reconfiguration	ESHT	1,500	23/24
16	8	Shoreham Integrated Community Hub	CWS CCG	6,000	22/23
19	9	Horsham Community Hospital	HMS CCG	25,000	23/24
23	10	Worthing Critical Care - right sizing project	WSFT	5,800	20/21
24	11	Bognor Health Centre redevelopment	CWS CCG	15,000	24/25
26	12	Maternity Configuration	ESHT	8,000	24/25
29	13	Lancing health centre	CWS CCG	7,000	24/25
31	14	MRI	QVH	1,635	20/21
32	15	Crawley Hospital Child Development Centre	Crawley CCG	3,800	20/21
33	16	Medical Day case unit at Conquest	ESHT	2,750	20/21
52	17	North Horsham Holbrook	HMS CCG	1,000	20/21
59	18	Day case unit at EDGH	ESHT	8,000	21/22
62	19	Ophthalmology: service modernisation/relocation	ESHT	8,013	21/22
66	20	Non-clinical space rationalisation	ESHT	1,500	21/22
68	21	EDGH Residential enabling scheme	ESHT	16,675	24/25

Figure 74: System-wide schemes prioritised for capital expenditure

Delivery of STP capital projects

The Sussex Health and Care Partnership has four approved STP capital schemes - the Wave 3 Pathology Centralisation project and three Wave 4 ambulance projects. Whilst the system submitted nine urgent projects (excluding the ambulance projects) for Wave 4 funding to support delivery of the key strategic objectives, these were unsuccessful. The total cost of these projects was £391.9 million, of which £77.2 million was sought for funding from Wave 4.

Of the four successful schemes, two have now received DH business case approval and construction has started on site.

An overview of these schemes is set out in the table below:

Lead Organisation	Title of Scheme	Scheme Description	Total STP Capital Funding (£,000)	FBC Approval
South East Coast Ambulance Service NHS Foundation Trust (SECAmb)	Worthing Make Ready Centre (MRC)	Centralisation of staff and expansion of the Make Ready facilities at Worthing MRC	235	approved
South East Coast Ambulance Service NHS Foundation Trust (SECAmb)	Brighton Make Ready Centre (MRC)	Centralisation of staff and expansion of the Make Ready facilities at Brighton MRC	5,520	approved
South East Coast Ambulance Service NHS Foundation Trust (SECAmb)	Expansion of additional floor space at the Trust Headquarters building	Acquisition of the second and third floors, Nexus House, via an operating lease and capital costs for the development of the site to make it operational	6,710	01/11/2019
Surrey and Sussex Healthcare NHS Trust	Clinical pathology hub	Centralisation of pathology services between three acute trusts as second stage of implementation of Pathology Network 7 consolidation plan	19,334	31/12/19

Figure 75: Four approved STP Capital schemes

9.2.5. **Disposals**

The Sussex Health and Care Partnership has developed a system-wide disposal plan to support the identification and disposal of surplus land and estate. Progress is actively managed at the monthly Estates Programme Board.

The value of disposals identified by the system exceeds the national “Naylor Fair Shares” disposal target of £75.7m by £37.97m. The system has identified 1,222 housing units against the “Naylor target” of 1164. This demonstrates an additional 58 housing units above the Naylor target. This figure is conservative and likely to increase once disposals have come to fruition.

In the past 12-month period, 11 sites have been sold and two sites removed from the plan (one was out of area and one has been withdrawn). Six further sites have been added.

The summary disposal programme is set out in the table below.

Number of Disposals	Land Area – hectares	Estimated Sale Receipt	Estimated Housing Numbers
44	21.93	£113.67 million	1,222

9.2.6. Governance and programme management

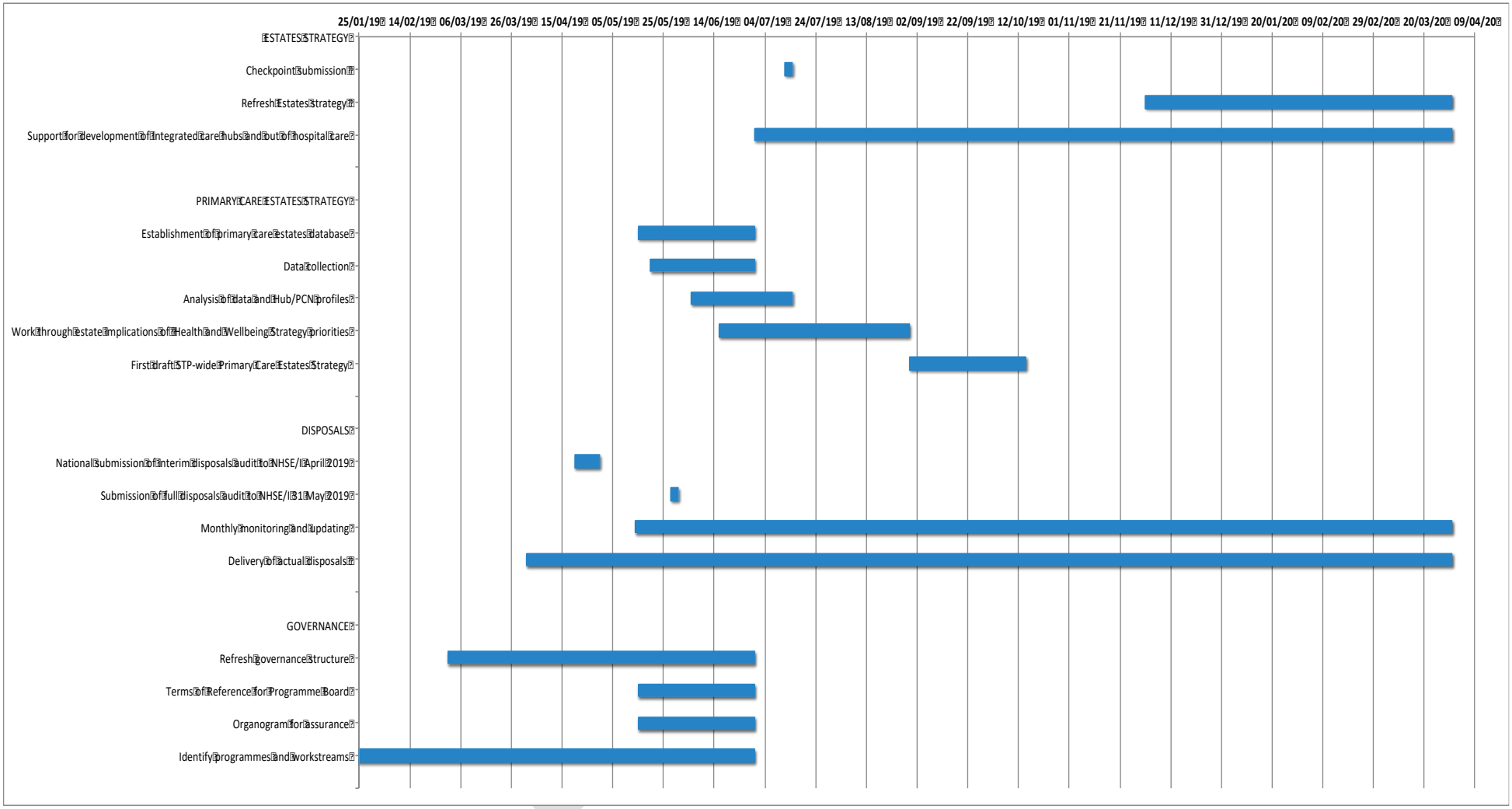
The Estates Programme is embedded within the Sussex Health and Care Partnership governance structure, and the Estates Programme Board reports monthly to the Portfolio Management Board on delivery, finance, and milestones, while highlighting any risks associated with achieving benefits and outcomes. There are highlight reports for the major projects and the key strategic themes. The Programme also updates the STP Finance Group on progress.

As the ICS develops, the Estates Programme will become more dynamically aligned to the new integrated care hubs and PCNs. Estates will work closely with Digital and Workforce plans as an enabler to the development and expansion of integrated care networks, with the provision of buildings as platforms to support physical and virtual co-located working for multiple agencies; at the same time, improving public access and facilitating end-to-end patient journeys.

The Estates Programme Board will oversee assurance within the Estates Programme to ensure that it is both properly aligned to other workstreams and delivering on what is needed for the ICS to take shape.

9.2.7. Delivery plan

The summary delivery plan is set out below across the two tables:


25/01/19
14/02/19
06/03/19
26/03/19
15/04/19
05/05/19
25/05/19
14/06/19
04/07/19
24/07/19
13/08/19
02/09/19
22/09/19
12/10/19
01/11/19
21/11/19
11/12/19
31/12/19
20/01/20
09/02/20
29/02/20
20/03/20
09/04/20
ESTATES STRATEGY
Checkpoint submission
Refresh Estates strategy
Support for development of Integrated care hubs and out of hospital care
PRIMARY CARE ESTATES STRATEGY
Establishment of primary care estates database
Data collection
Analysis of data and Hub/PCN profiles
Work through estate implications of the Health and Wellbeing Strategy priorities
First draft STP-wide Primary Care Estates Strategy
DISPOSALS
National submission of interim disposals audit to NHSE/I April 2019
Submission of full disposals audit to NHSE/I 31 May 2019
Monthly monitoring and updating
Delivery of actual disposals
GOVERNANCE
Refresh governance structure
Terms of Reference for Programme Board
Organogram for assurance
Identify programmes and workstreams

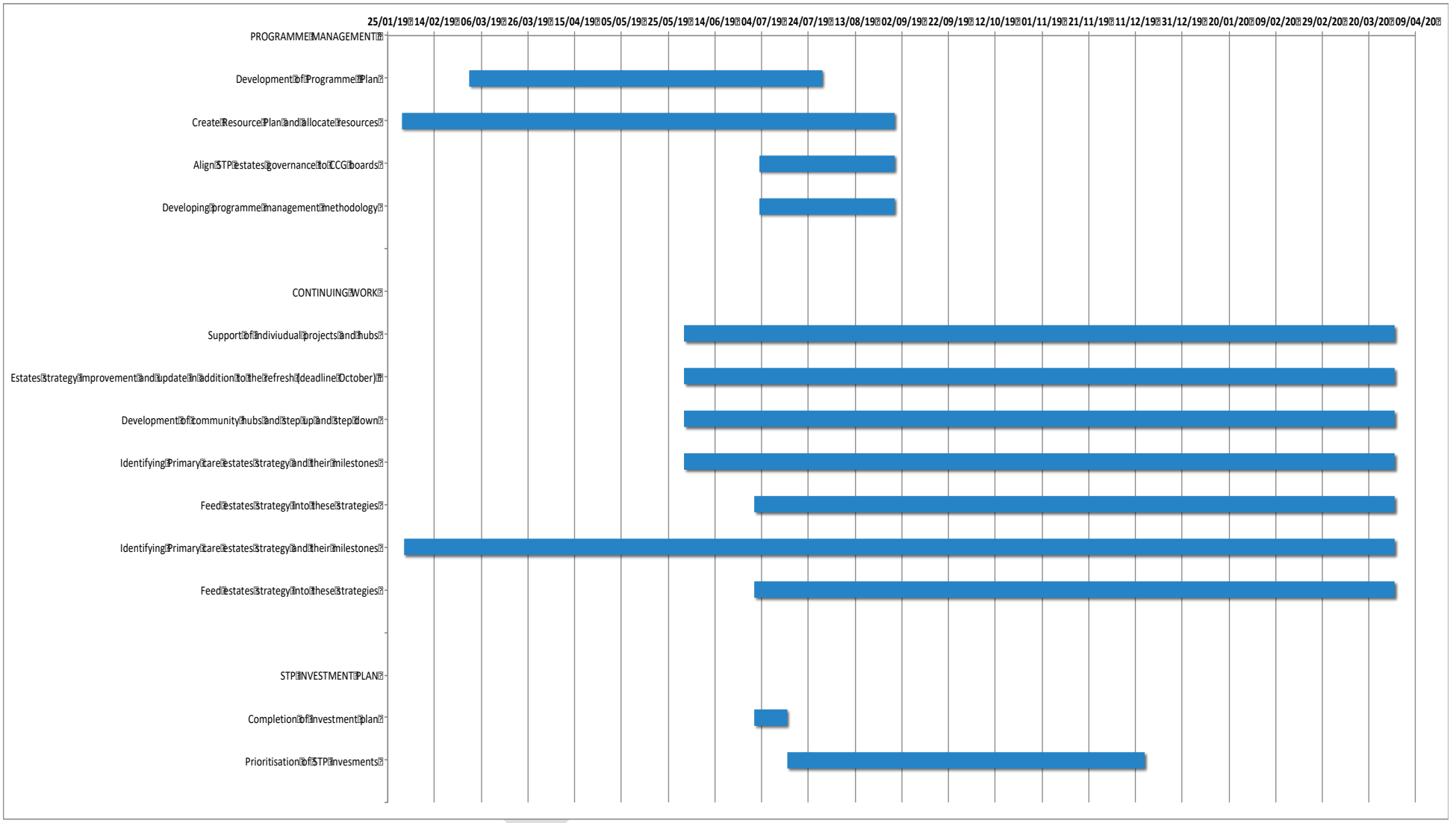


Figure 76: Summary Delivery Plan

10. Programme governance

10.1. Governance and monitoring delivery

There are many change programmes working across the Sussex Health and Care Partnership portfolio as shown below.

- Theatre efficiency
- Cancer Alliance
- Outpatient development
- ICP development
- ICS accelerator
- CCG transition
- Personalisation of care
- Head and neck
- Diabetes
- Dermatology
- Mental health
- CEC/POLCE
- Back office
- CHC
- Step Up Step Down (Community responsiveness)
- Urgent and emergency care
- Estates
- Digital
- Workforce
- Maternity
- Unwarranted Clinical Variation (MSK, CVD and Falls & Fragility)
- Medication management
- Procurement

An overall Programme Director and Programme Management Office (PMO) is in place to maintain oversight and control of these programmes. The monthly portfolio review process ensures there is high quality planning and delivery from the individual workstreams, and a less formal weekly meeting allows the Programme Leads time to manage the interdependencies between the schemes and design universal communications for all stakeholders.

There are senior leads for each of the programmes and some also have clinical leads. It is recognised that there is a very wide range of programmes and so the portfolio is currently being reviewed to ensure that the leadership, governance, support and delivery outcomes are robust. This will align the current local programmes to LTP requirements, for instance Stroke and Ageing Well, and streamline the delivery approach.

The review of portfolio governance is due to be completed in November 2019 and at that stage programme reporting and support is likely to change. In advance of these changes, the principles by which the portfolio is governed have been agreed by the Partnership Executive:

- The portfolio of programmes will support collaborative working by the way the programmes are set up and delivered.
- Partners maintain control of the transformational changes, can be assured of delivery, but with appropriate level of detail. The Partnership Executive group will not be the Programme Board, but will have visibility to be assured of programme developments.
- Each programme will have a Board, with a Programme Lead, SRO and Executive Sponsor. Each Programme Board will be self-managing and capable of delivering its agreed outcomes and escalating when necessary.
- Each programme will report into one of the Partnership Groups, to ensure alignment between similar programmes, agree scope, timescales and outcomes for the programme, and provide the point of escalation for programme issues.

- All programmes will be coordinated and supported through a Portfolio Management Group to manage the interdependencies, risk, communications, finance and escalation of issues.
- Programmes to do with clinical pathways and practice will be led by providers. Programmes to do with system structures will be led by commissioners. All programme boards will have a collaborative approach with commissioners and providers.
- There will be a universal offering of administration and programme management support for all agreed programmes of work.
- All programmes will report at least monthly.

The governance of the delivery programmes will also be reviewed to ensure that the Clinical and Professional Cabinet has a stronger role in setting and assuring meaningful outcomes to enable outcomes-based commissioning.

10.2. Quality and assurance

Within Sussex, the Quality and Safeguarding directorate works in partnership with providers and partners to drive up the quality of services for our population. As we undertake this wide scale system reform, it becomes even more important to ensure we continue to provide services of the highest quality, delivered with respect and compassion, and a positive experience for our population.

As we mature towards becoming an ICS over the next six months, we are reviewing our other system-wide governance including the groups overseeing strategy and the groups overseeing operational delivery to ensure clear direction for, and delivery of, our priorities. We propose also to develop a Quality and Performance Improvement Group to take collective oversight of problem solving for escalated concerns and sharing best practice.

Integrated assurance will take place at each level, retaining a clear line of sight for system, local place and individual organisational performance, with ability to report at each level if required. For more information, please see our 'Quality and Assurance Improvement Framework' developed in collaboration with CCGs and NHS England and implemented from 1 April 2019.

10.2.1. Quality and safety improvement for all services including non-NHS providers

Through our continuous quality improvement programme, working closely with providers of health and care we will continue to drive for outstanding care in the NHS services we directly commission and in the independent, non-NHS and care sectors. This will include the following providers of health and care:

- NHS trusts
- Community providers
- Independent providers
- Care and nursing homes
- Primary and community care providers

Our continued aim will be to strive for excellence through effective commissioning of high quality services that reduce avoidable harm and create the best environment for patients. This will be in line with meeting the requirements of the NHS constitutional standards, the Long Term Plan, the Interim People Plan and our local Patient Safety Strategy. We will have a particular focus on areas

identified by our early warning system where standards are falling below par, such as Referral to Treatment and Cancer Waiting Times. This will be achieved by continuing to work together with provider clinical teams, Continuing Healthcare, and commissioning teams from health and care, whilst embedding our good practice approach to reviewing and learning from clinical harms.

Our overall approach consists of the following elements:

- Ensuring risks are assessed, recorded and reviewed as part of our corporate risk registers
- Applying a systematic, well-governed approach to implementing high quality cost effective sustainable improvements using our established quality assurance and improvement framework
- Working in partnership with local authorities, patients, their families and carers to design and redesign services that meet their needs and deliver improvements to care and support
- Applying a rigorous approach to quality improvement measures, with a focus on improving outcomes for people, reducing health inequalities, and holding providers to account for the delivery of high quality safe care
- Effectively engaging system partners both from within the organisations and externally by regularly communicating our progress
- Fostering a culture of celebrating successes and collectively learning how to improve.

10.2.2. Patient safety

The Sussex Partnership aims to deliver effective leadership at all levels to embed a patient safety culture in line with our robust patient safety system. Our approach will be fully aligned with the NHS Patient Safety Strategy's three strategic aims to:

Insight	Improve understanding of safety by drawing intelligence from multiple sources of patient safety information
Involvement	Equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system
Improvement	Design and support programmes that deliver effective and sustainable change in the most important areas

Figure 77: Our approach to patient safety

The Sussex patient safety approach consists of the following elements which we will constantly refine through our learnings from partnership working across our local system:

- Set and closely monitor agreed patient safety measures with all providers (commissioned and non-commissioned services)
- Identify, investigate, report and learn from incidents through strong, effective, well-governed mechanisms
- Ensure our Safety Scrutiny Panels and Quality Committees are well-led and enabled to recommend/assure Governing Bodies
- Identify and respond to themes and trends for improvement as part of our established quality assurance and improvement framework, and use these to inform our system priorities for continuous quality improvement
- Ensure that delivery of our approach to learning from all deaths/preventing future deaths is systematic and robust, with learning enabled system-wide

- Agree specific recovery plans and improvement interventions jointly with commissioning teams and providers, holding providers to account for timely delivery
- Facilitate local learning events to celebrate learning together
- In line with Duty of Candour, adopt an open, transparent approach involving patients, their families and carers in all aspects of serious incidents.

10.2.3. Managing provider performance

Our aim is to continue to work jointly with our providers of health and care, building on our proven track record to improve the care they deliver. Through our recognised quality improvement work, we are committed to building upon current progress to ensure that:

- Our organisations sustain their 'outstanding' statuses awarded by the Care Quality Commission
- We support those awarded 'good' to aspire to the delivery of outstanding care
- For those currently rated as 'requires improvement', we support individual recovery plans to target quality improvement

In the event that we have a poorly performing provider, we would establish an improvement plan in collaboration with the provider, typically consisting of the following elements:

- Workforce
- Meeting the needs of people with deteriorating physical and psychological health
- Care planning, including personalisation and management of clinical risk
- Managing clinical conditions and presentations
- Local quality assurance and improvement monitoring
- Engagement and experience of people we support
- Safeguarding
- Communication and enhancing the well-led ethos.

10.2.4. Ensuring quality and safeguarding

All commissioning plans will be assessed for their impact on quality for patients, including impacts on equality and health inequality. In 2018/19, a revised Quality Impact Assessment Policy for Sussex and East Surrey was introduced. This has been revised to incorporate equality and health inequalities impact assessments in line with the LTP and our local priorities. We also measure quality using CCG Quality Assurance and Improvement frameworks to provide a structured approach to escalating quality concerns using a risk-based methodology. This will enable the commissioning quality team to proactively safeguard people, using a consistent evidence-based approach. Interventions to improve care delivery will be coordinated and delivered collaboratively across all system partners.

The Quality and Safeguarding directorate will work alongside our commissioning teams to:

- Monitor the performance of providers against agreed quality standards and outcomes using all contractually-reported indicators relating to patient experience, patient safety (including safeguarding) and clinical effectiveness
- Ensure that there are processes and procedures in place with providers to evaluate and mitigate the impact for patients where constitutional standards are not being met
- Carry out surveillance in line with the Care Quality Commission 'domains' (safety, effectiveness, patient experience, leadership, culture and responsiveness)

- Use the Commissioning for Quality and Innovation (CQUIN) payment framework to support local improvement.
- Undertake quality assurance visits to services where quality concerns have been identified.

10.2.5. Our quality and safety priorities

In delivering on all of the commitments within the Long Term Plan, we will continue our journey of continuous quality assurance and improvement against our quality and safety priorities across Sussex. This includes:

- Commissioning services in line with national quality standards and local clinical priorities
- Aiming for 'harm free care' – pursuing a patient safety culture of continuous learning and quality improvement, effectively managing serious incidents and assessing the level of risk and action required, ensuring system-wide trends are identified for improvement and system-wide learning is embedded
- Safeguarding vulnerable populations and protecting adults and children from harm in partnership with our local authorities
- Developing a capable, confident competent workforce to deliver high quality safe care
- Learning from our patients – complaints, feedback, and surveys will continue to be important sources for measuring our progress and determining whether we are meeting local populations' needs.

Although we have identified these as Sussex-wide priorities for the Quality and Safeguarding directorate, quality assurance is integral to our whole strategy. Therefore, for more information on addressing quality in primary care, please see section 4.3 on primary care networks, and how they will drive improved health outcomes through greater investment, enhanced community partnerships, greater collaboration and more multidisciplinary working. Similarly, within urgent and emergency care, we are improving standards through programmes to reduce pressure on A&E, implement UTCs, improve discharges and reduce DTOCs, all of which are explained in section 7.1.2.

Learning from serious incidents

Sussex will continue to support its CCGs to fulfil their statutory responsibilities for management of serious incidents reported by commissioned services. There is a patient safety team based at Brighton & Hove CCG who provide oversight and effective management of serious incidents for all providers across Sussex. All serious incident investigations will be reviewed at a fortnightly Serious Incident Scrutiny Group.

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

Infection prevention

We will drive improvements that reduce the incidence of healthcare acquired infections by taking a proactive approach to achieving reduction targets, including through the development of a two-year clinical strategy.

Infectious outbreaks can affect the delivery of local services, especially during the winter period, resulting in ward or bay closures in acute and community in-patient areas and nursing homes. To manage this effectively, we have agreed a system-wide approach to managing infectious outbreaks during periods of escalation which includes the management of influenza in and out of season. Implementation of this system-wide protocol will mitigate against risks to manage outbreak situations.

Workforce development

The commissioning quality team will work with providers to ensure they: have effective retention plans in place that focus on engaging and empowering the workforce; understand and are acting upon insights such as the reasons why people leave; and are taking sustainable action to retain staff. We will also work closely with trusts to ensure that safer staffing levels are maintained through robust clinical risk assessment. Local workstreams include:

- Apprenticeships – assistant practitioners and nurse associates
- Reduction in nursing vacancies, with a focus on learning disabilities and practice nurses
- Work with Health Education England (HEE) to influence education commissioning, reduce attrition, increase clinical placements, and make Sussex the 'Best Place to Work'
- International recruitment programme
- Retention: 'Best Place to Work' initiatives for all clinical staff groups supported by our ICS workforce workstream, HEE and the SES Training Hub
- Leadership development and talent management.

Progress updates on the above initiatives will be provided at contractual quality review meetings.

Safeguarding adults, children and looked after children

The safeguarding team holds statutory responsibilities in relation to safeguarding adults, children and looked after children within our local populations. This includes the requirement for providers to complete bi-annual self-assessments against an approved Safeguarding Assurance Framework and submission of quarterly exceptions reports.

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

During the period of our five-year strategy, work will include implementation of the new arrangements for 'Working Together to Safeguard Children' and of any needed improvements arising from the CQC inspection undertaken in Brighton & Hove in July 2019, focussing on safeguarding of children and Looked After Children.

Improving the patient's experience

- System learning from incidents and from complaints and feedback. This comes from patient reference groups/patient participation groups and campaigns such as 'You Said We Did' and 'The Big Conversation'.
- Involving and engaging patients and the public in developing, reviewing, decommissioning and recommissioning local services. Over 1,500 people have contributed to our strategy through local events on the Long Term Plan and Healthwatch events. The public will have the opportunity to provide feedback on our strategy, including on key clinical priorities and the reorganisation of local services.
- Social prescribing to reduce inequalities in access and health outcomes.
- Improving access, early diagnosis, and personalised support to help people self-manage long term conditions.

10.3. Moving into operational delivery planning

Our Strategy Delivery Plan aims to deliver better health and care outcomes for our population by

reforming how our Sussex health and care organisations work together, transforming patient pathways, and delivering the significant number of initiatives included within the Long Term Plan. This must be delivered in the context of a challenged health and care economy with increasingly stringent financial controls and a significant workforce gap, as well as a wider national context of declining performance against key access standards.

We are committed to delivering against our strategic vision as described in this plan, but we also appreciate that delivery of all these commitments will require profound and extensive system transformation.

As we move into operational delivery planning, we will develop and agree a Sussex-wide prioritisation methodology and framework, which can be used for decision making at all levels across Sussex. This prioritisation framework will allow us to collectively:

- Prioritise the right changes, service models or innovations, targeting those that will deliver the greatest value, and help us to focus system-wide resource and effort
- Have a fair, transparent and robust decision making process which can be applied consistently at system, place and neighbourhood level
- Ensure choices are consistent and coherent with our strategic vision
- Enable delegated decision making, where appropriate, to provide us with the bandwidth to make decisions at different levels.

We have developed a draft prioritisation framework to test and agree across the partnership, which is based upon alignment to our strategy, impact and resource requirements:

Category	Element to consider and score against
Alignment to Sussex Partnership need or priority	Extent to which idea/desired change **addresses a Population Health Check need**
	Extent to which idea/desired change **addresses an NHS Long Term Plan 'must-do'** or priority
	Extent to which idea/desired change **aligns with over-riding ICS strategy**
Impact or outcome	Estimated **size and reach of positive impact on patient-defined outcome,** and when it will occur ○ To consider number of people impacted, and size of impact on each individual, and time lag before impact seen
	Extent to which idea/desired change **addresses the 'three gaps'** ○ Health and wellbeing ○ Quality ○ Finance

	Extent to which the idea or desired change has **unintended negative consequences** in other parts of the system, which could include: ○ Compromising access – e.g. closure of services elsewhere in the system ○ Compromising quality – e.g. pulling expertise away from areas of need ○ Compromising sustainability – e.g. reducing activity to below sustainable levels elsewhere in the system
Resource required	**Financial investment or cost** of progressing and delivering idea/desired change ○ To include the cost of disinvesting in other ideas, initiatives or services
	Non-financial resource required to progress and deliver idea, to include: ○ Time ○ Space ○ People
	Ease of implementation and likelihood of success, including size of barriers to delivery

Figure 78: Draft prioritisation framework

While our Strategic Delivery Plan sets out what we want to achieve and the principles of how we will work together differently, our operational planning will set out how we will achieve this, what needs to change to enable this, and how we will monitor achievement of our objectives.

Starting in October 2019, we are asking each of our programmes to build upon their strategic planning and move immediately into operational planning, using the delivery framework below as a consistent way of framing our operational plans.

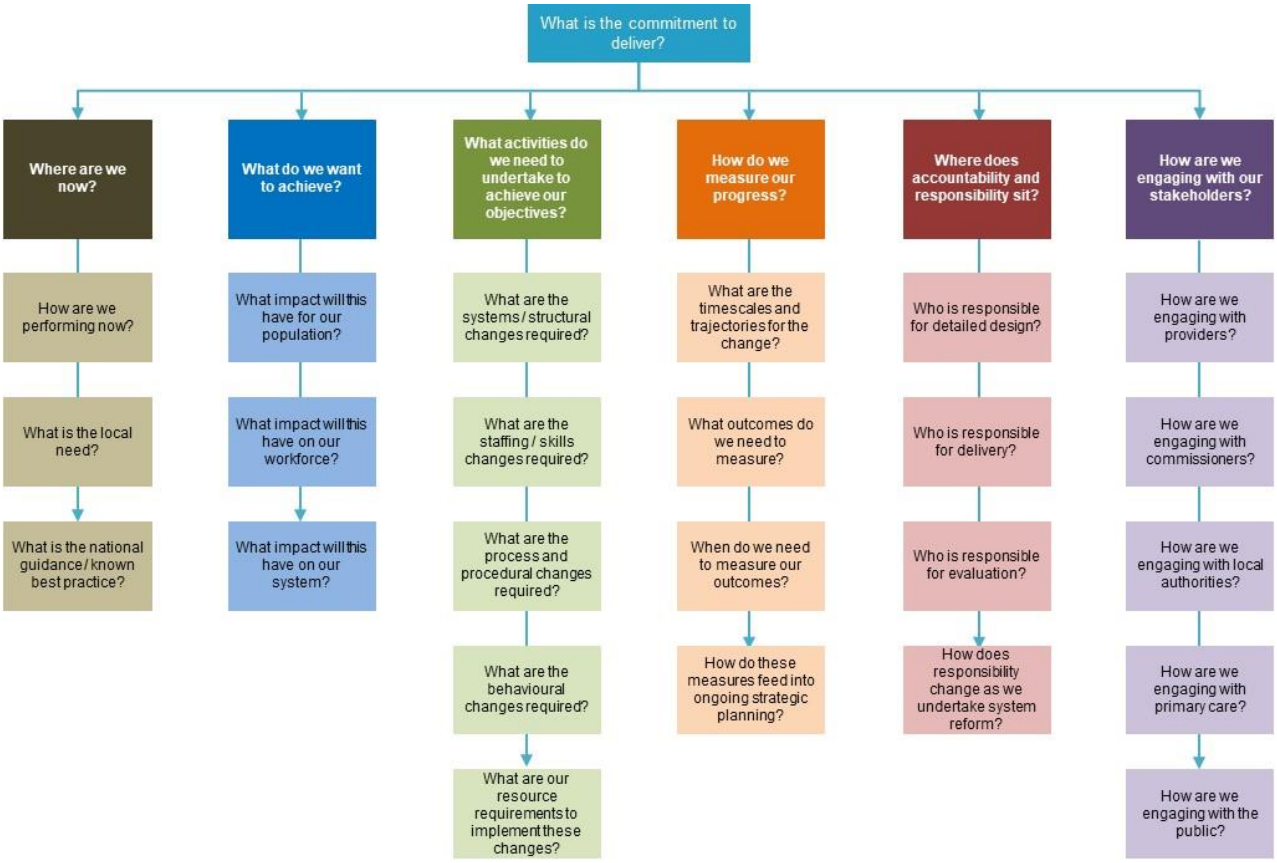


Figure 79: Draft delivery framework for programmes to use as they move into operational planning

10.4. Major risks and mitigating actions

The following list of major risks to delivering the Strategy Delivery Plan and mitigating actions is shown below.

Note: This list will continue to develop with ongoing input from each workstream and risk owner.

Risk description	L	I	Score	Owner	Mitigation
Unable to deliver financial improvement trajectory leading to growing deficit and loss of transformation funding	4	4	16	Finance Group	Monthly financial reporting process overseen by Finance Group, which monitors year-to-date position. Key issues and significant variance from trajectory together with mitigating actions. System assurance meetings monitor financial position at ICP/place-based level and develop mitigating actions.
Lack of investment in key areas leads to constraint on delivery	4	4	16	Partnership Executive	Strong governance of programmes to ensure delivery and feedback on performance. Regular reporting to

of ambitions					enable targeting of investment into key areas of delivery.
Insufficient capacity within partner organisations to progress all ambitions in the plan to the timetable set out	4	4	16	Partnership Executive	Allocated resource available from to priority areas. Where resource cannot be identified (e.g. not recruited) review prioritisation of plans.
Workforce planning assumptions are not correct leading to actions not adequately addressing them	4	4	16	LWAB	Regular review of planning assumptions by monitoring current workforce position in Strategic Workforce Group, and of future activity assumptions with Finance Group.
Role and aims of the Partnership are not clearly articulated leading to confusion and misalignment	3	5	15	Partnership Executive	Re-state the aims and purpose of the Partnership through the Local Strategic Plan.
Transformational changes required to secondary and tertiary care services are not undertaken in a managed way, leading to increased **unsustainability of acute services**	3	5	15	Sussex Acute Collaborative Network	SACN to identify current and potential fragile services and ensure that Sussex-wide proposals are developed to address these to ensure long term clinical sustainability.
Lack of clarity around priorities and responsibilities leading to delays and poor delivery	5	3	15	Partnership Executive	Coordination of the Partnership Population Heath Check. Local Strategic Plan and response to the NHS Long Term Plan.
Population health and commissioning outcomes are insufficiently supported leading to poor planning and delivery	3	4	12	Directors of Strategy	Continued Director of Strategy engagement with prospective partner organisations at Partnership Executive; at place; and one-to –one. Directors of Strategy and Communications work with prospective partners to develop strategy to raise awareness of population health amongst partners

DRAFT

					and with communities.
Lack of agreement about implementation of some initiatives, leading to delays or poor delivery of benefits	4	3	12	Partnership Executive	Open discussion with leaders in partner organisations. Where appropriate facilitation of discussion on priorities.
Estates challenges and timescales constrain acute trusts' ability to deliver the optimum service model for UTC services	4	3	12	UEC group	Change in estate requirements to be understood and assessed against pathway impact. This will form part of the NHSE-I assurance process. Period of transition involving workarounds to ensure the core 27 standards can still be met and access to services is not constrained.
Insufficient focus on patient care during system transitions, jeopardising continuity, safety or quality	3	4	12	Clinical and Professional Cabinet	Major change programmesratified by the Clinical and Professional Cabinet to ensure appropriate clinical engagement and patient focus. Revised Quality Impact Assessment Policy used to assess the impact for patients in all programmes.
Key information is unavailable across the system to inform strategy and action	3	4	12	Directors of Strategy	Work to identify missing information and agree approaches to gathering it (e.g. information on student fill and attrition rates).
Lack of genuine collaborative and transparent joint working leading to misaligned incentives and poor delivery	3	4	12	Partnership Executive	Agreement between organisations to share data. Open-book approach to planning and a move towards strategic commissioning.
Excessive focus on NHS acute services to the detriment of local authorities, primary care, community care and	3	4	12	Partnership Executive	Formal involvement of local authorities and primary care in the working of the Partnership. Collaboration beyond health partners, to include the voluntary sector.

prevention					
System financially challenged, in terms of both revenue and capital, impacting its relationship with regulators	3	4	12	Partnership Executive	Open-book collaborative working in STP Finance Group. Aligned responses to regulators from STP, rather than organisations acting independently.
Workforce interventions do not have the planned impact – leading to the workforce plan not being achieved to the planned timetable	3	4	12	LWAB	Monitor impact of workforce interventions through LWAB and sub-groups. Adjust plans or develop further workforce interventions as appropriate.
Priority clinical group workforce plans are not sufficiently clear to enable timely development of workforce plans	4	3	12	LWAB	Support priority clinical groups to develop their workforce plans.
Partnership infrastructure is unclear with poorly established governance and leadership leading to lack of delivery capability	2	5	10	Partnership Executive	Continued strengthening and formalisation of STP governance. Identification of STP/ICS Lead, with authority/credibility to act.
Lack of dedicated resource to deliver the Partnership aims	2	5	10	Portfolio Delivery Group	Dedicated internal resource identified by all organisations, to work on Partnership issues.
Fixed term contracts for programme resources end in March, potentially disrupting planning and delivery	2	5	10	Portfolio Delivery Group	Develop transition and continuity plans to enable internal organisational resource to continue work as needed.
Variation in approach between partners means that financial efficiencies take more time than	3	3	9	Partnership Executive	Ensure alignment of approach through the development of the Local Strategic Plan and monthly meetings to review strategic priorities and planning.

DRAFT

planned					
CCG headcount reduction means that we are relying on staff and managers who are disaffected to perform key transition functions leading to delays on poor performance	3	3	9	SES transition	Deliver an honest, open and transparent process with CCG managers and staff ensuring that they are engaged, and that the rationale for change is clearly and compassionately articulated.
Priority clinical group workforce plans may **increase demand for staff groups** in short supply – affecting the delivery of these plans and/or current services	3	3	9	LWAB	Workforce plans for new services reflect current work supply and phasing of implementation is coordinated with relevant partners.
Retention and/or staff engagement may decrease as a result of workforce transformation	3	3	9	LWAB	Workforce transformation planned and communicated clearly to staff, considering best practice HR and OD practices.
Workstream **does not identify appropriate practical metrics** to measure the impact of actions	3	3	9	LWAB	LWAB oversee the identification of suitable metrics. Where appropriate this is informed by third party advice on evaluation (e.g. AHSN, universities).
Key information is not available to inform strategy and action	3	3	9	LWAB	LWAB works to identify missing information and agree approaches to gathering it (e.g. information on student fill and attrition rates).
There is **insufficient capacity within partner organisations** and/or HCP workforce team to progress all ambitions in the plan to the timetable set out	3	3	9	LWAB	Allocated resource available from HEE and NHSI/E to priority areas. Where resource can not be identified (e.g. not recruited) review prioritisation of plans.

DRAFT

Partner organisations do not agree about implementation of some workforce initiatives, diminishing the impact of work across the system	3	3	9	LWAB	Open discussion with leaders in partner organisations. Where appropriate facilitation of discussion on priorities.
CCG staff consultation slips or needs to take more than 30 days, meaning staff will be going through change during peak winter season and Christmas	2	4	8	SES Transition Board	Develop and manage a robust consultation process, in which issues and concerns are quickly resolved or escalated to ensure timelines are met.
Financial planning assumptions are not agreed by system partners leading to dis-coordinated planning and misaligned incentives	2	4	8	Finance Group	The financial framework is developed by the Finance Group to underpin the financial strategy. We have an open and transparent Finance Group and a system-wide financial model with collaborative system-wide input which informs strategic planning.
ICP footprints cannot be agreed leading to delays	2	4	8	Directors of Strategy	Continued Director of Strategy engagement with prospective partner organisations at Partnership executive; at place; and one-to–one
Misaligned organisational incentives present a risk to system-wide financial improvement and sustainability	2	4	8	Finance Group	The majority of contracts in the system are based upon aligned incentives, which mitigates the risk of provider over-performance on activity. Finance Group are currently examining options with the support of the national payment reform team to move towards more sophisticated risk sharing blended payment models.
Complexity of overall programme of work with all partner organisations leads to **unplanned and/or**	3	2	6	LWAB	Oversight of development of workforce interventions through robust LWAB governance structure. Monitoring of impact of workforce

unintended workforce implications					interventions through agreed metrics and local intelligence.
Review by NHS X delays or stops national digital funding initiatives	2	3	6	Digital Lead	Close relationship management with NHS E/I to ensure targeting of investment opportunities, including ability to respond rapidly. Successful outcomes and strong positive feedback to recent bidding is improving the position.
East Surrey transition delayed meaning Sussex will not be able to fully transition to shadow form	1	4	4	SES transition	Co-define and drive a clear transition plan for East Surrey, ensuring that there is appropriate governance and a clear escalation route to manage any slippage.

DRAFT

Sussex
Health and Care Partnership

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



Brighton & Hove Response to the NHS Long Term Plan

Delivering the NHS response as part of our Joint Health and Wellbeing Vision for our Population

October 2019

Revised Draft

Patient-centred
Partnership
Transformation
Sussex
Health
Integration
Sustainability
Social care

Table of Contents

1. Purpose of our plan 4
2. Where we are today 5
   2.1 Our population 5
   2.2 The bigger picture and wider determinants of health 6
   2.3 Our current health and care provision 10
      2.3.1 Brighton & Sussex University Hospitals NHS Trust 10
      2.3.2 Sussex Community NHS Foundation Trust 11
      2.3.3 Sussex Partnership NHS Foundation Trust 11
      2.3.4 South East Coast Ambulance Service 11
3. Our approach in Brighton & Hove 12
   3.1 Our health and wellbeing vision 12
   3.2 Our system priorities 13
   3.3 Our approaches to underpin our collaborative system 13
   3.4 System transformation through integration 14
      3.4.1 Primary Care Networks 16
      3.4.2 Enablers to integration - data 17
      3.4.3 Enablers to integration – clinical shadowing 17
   3.5 Our governance model, programme leadership and resourcing 18
   3.6 System roadmap 22
4 Meeting our NHS Long Term Plan commitments through the life course approach 23
   4.1 Starting Well 23
      4.1.1 Integrating children's and young people's services 23
      4.1.2 Implementing Sussex wide programmes of work 24
   4.2 Living Well 28
      4.2.1 Primary prevention 28
      4.2.2 Planned care 29
      4.2.3 Transforming outpatients 31
      4.2.4 Respiratory services 32
      4.2.5 Personalised care 33
      4.2.6 Local priorities: trans locally commissioned service in primary care 35
      4.2.7 Implementing Sussex wide programmes of work 35
   4.3 Ageing Well 41
      4.3.1 Transforming out of hospital and community care 41
      4.3.2 Other local plans to support Ageing Well 46
   4.4 Dying Well 48
5 Quality 50

6. Enablers 52
6.1 Digital 52
6.2 Estates 53
6.3 Workforce 54
Reference documents 55
Appendix 1: DRAFT population health outcome measures for the Joint Health and Wellbeing Strategy 56

1. Purpose of our plan

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

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

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

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

2. Where we are today

2.1 Our population

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

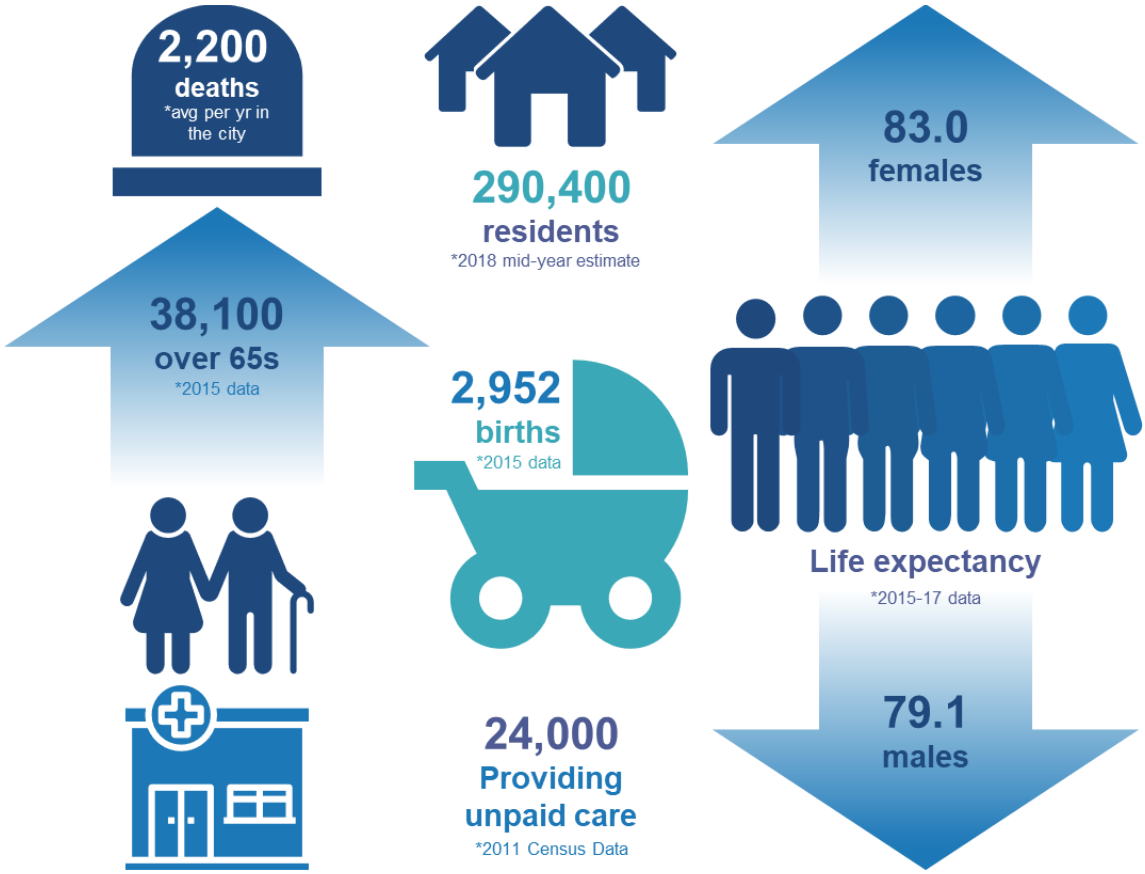


Figure 1: Our population

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

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

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

2.2 The bigger picture and wider determinants of health

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

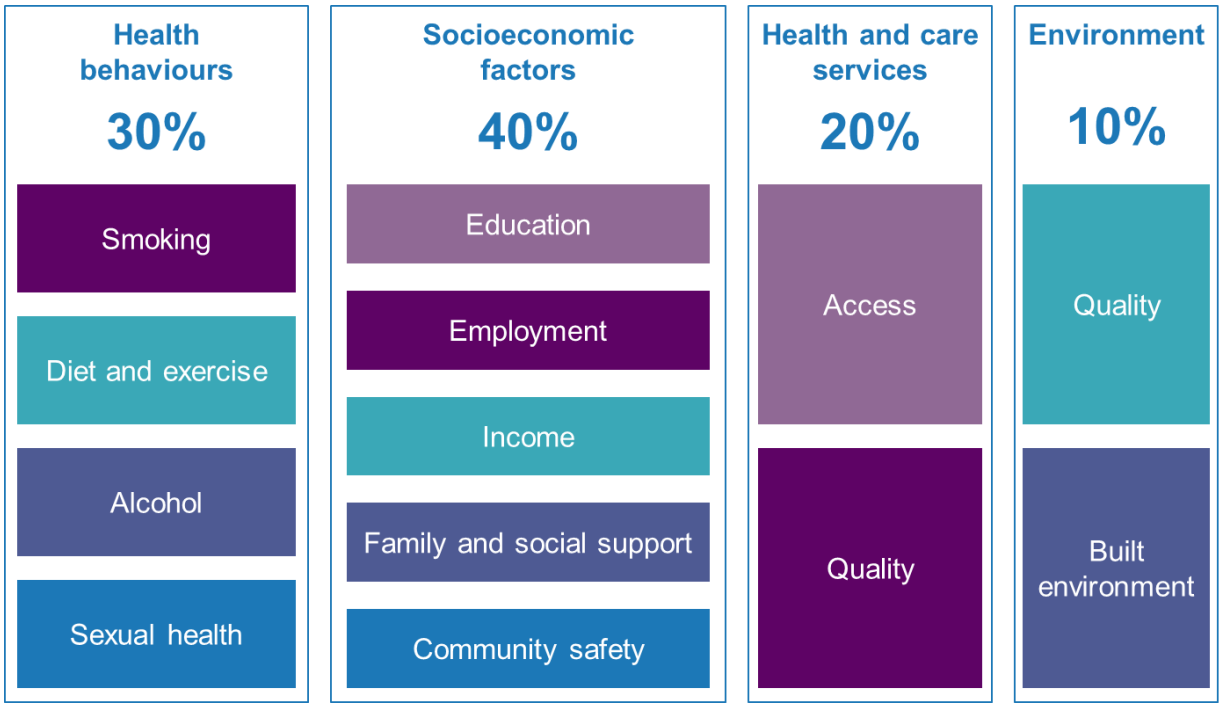
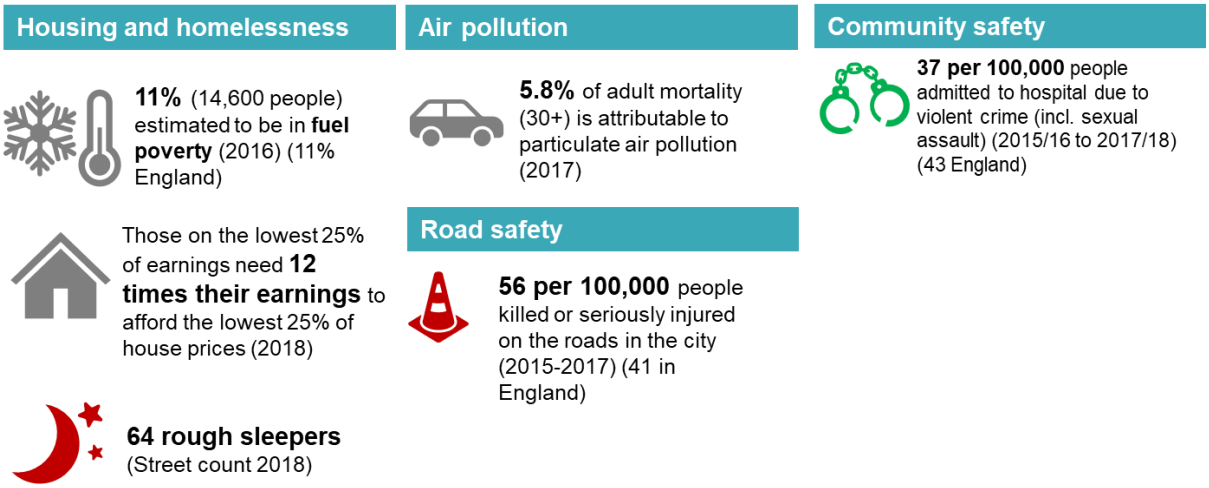


Figure 2: Wider determinants of health; Source: County Health Rankings Model 2014

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



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

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

Children in care

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

School readiness

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

Education

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

Child poverty

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

Youth unemployment

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

Disabilities and sensory impairments

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

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

Healthy weight

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

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

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

Maternal & infant health

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

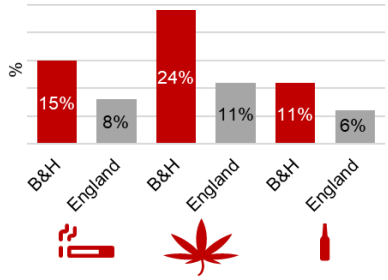
6% smoking at delivery 11% England (2017/18)

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

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

Young people

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



Emotional wellbeing

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

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

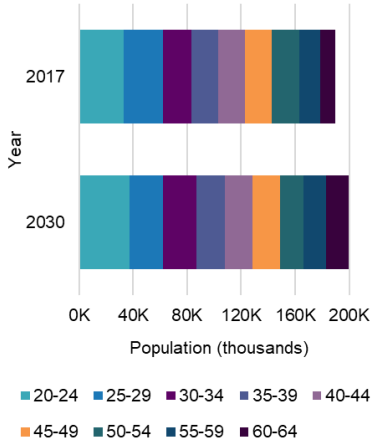
10% say that they often / sometimes hurt or harm themselves (2018)

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

Population

The number of 20-64 year olds is projected to increase by 5% (10,400) by 2030 from 189,500 to 199,900 people

The biggest % increase is expected in 60-64 year olds (45%), but falls in 25-29 year olds and 45-54 year olds



Employment and work

4.8% (7,700 people are unemployed (2017)

Employment rates are lower for those with: **long-term conditions**; **a learning disability**; and **those in contact with secondary mental health services** (2017/18)

4% of 16-64 year olds are out of work due to long-term sickness (Oct 2017 to Sept 2018)

£473 the median gross weekly earnings in pounds (2018 Provisional)

Healthy life expectancy

MALE	FEMALE

Life expectancy (2015-17)

79.1 years | **83.0** years

Healthy life expectancy (2015-17)

62.2 years | **65.3** years

There are large differences in both life expectancy and healthy life expectancy across the city

Lifestyles

19% of adults are current smokers (2018)

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

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

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

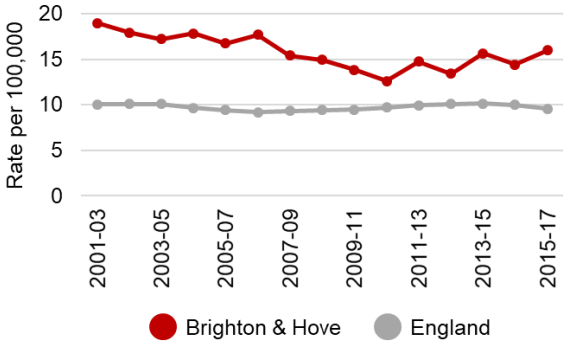
77% of adults are physically active and 16% inactive (2017/18)

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

Emotional health

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

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



Long-term conditions

There are over 51,000 adults (22%) aged 20+ with two or more long-term physical or mental health conditions in the city - with a strong link with deprivation

19,000 (8% of adults**)** have mental **and** physical health conditions

Without scaling up prevention, there will be **over 10,500 more adults** with two or more conditions **by 2030**

Global burden of disease

Locally, conditions with the greatest burden (2017) are:

- Cancers
- Musculoskeletal conditions
- Heart conditions
- Neurological conditions (including dementia)
- Mental health

Healthy life expectancy

MALE	FEMALE

Life expectancy (2015-17)

79.1 years | **83.0** years

Healthy life expectancy (2015-17)

62.2 years | **65.3** years

There are large differences in both life expectancy and healthy life expectancy across the city

Cancer screening

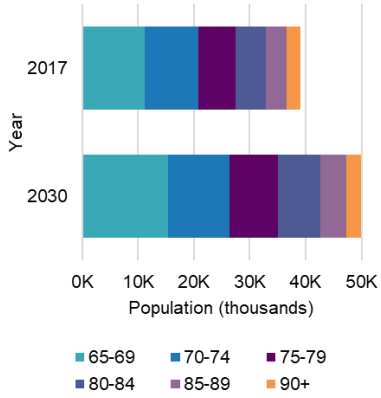
Screening rates for breast, cervical and bowel cancer are all lower than England

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

Population

The number of 65+ year olds is projected to increase by 28% (10,700) from 38,400 to 49,100 people between 2017 and 2030

The biggest % increase is expected in 80-84 years (43%, 2,300 more people) there are projected to be 700 more 85-89 year olds and 400 more 90+ year olds



Life expectancy at 65

Life expectancy at 65 is similar to England for males and females (2015-17)

MALE	FEMALE
18.6 years	**20.9** years

Social care

58% of those surveyed receiving adult social care had good quality of life (2017/18)

Similar carer quality of life to England (2016/17)

Social isolation

41% of people aged 65+ live alone according to the 2011 Census

20.5% of older people are income deprived (2015)

Dementia and sight loss

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

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

Falls and hip fractures

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

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

Flu immunisation

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

Place of death

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

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

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

2.3 Our current health and care provision

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

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

2.3.1 Brighton & Sussex University Hospitals NHS Trust

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

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

2.3.2 Sussex Community NHS Foundation Trust

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

2.3.3 Sussex Partnership NHS Foundation Trust

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

2.3.4 South East Coast Ambulance Service

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

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

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

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

3. Our approach in Brighton & Hove

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

3.1 Our health and wellbeing vision

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

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

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

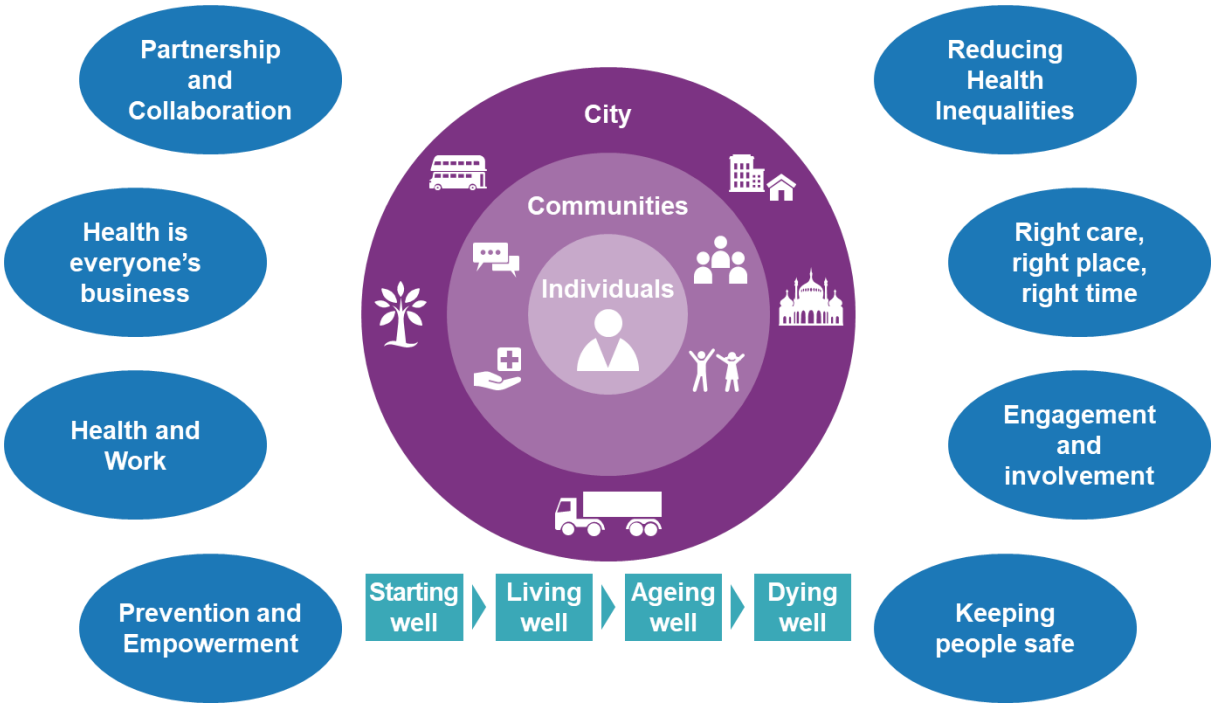


Figure 3: Our Health and Wellbeing Vision

3.2 Our system priorities

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

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

3.3 Our approaches to underpin our collaborative system

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

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

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

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

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

3.4 System transformation through integration

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

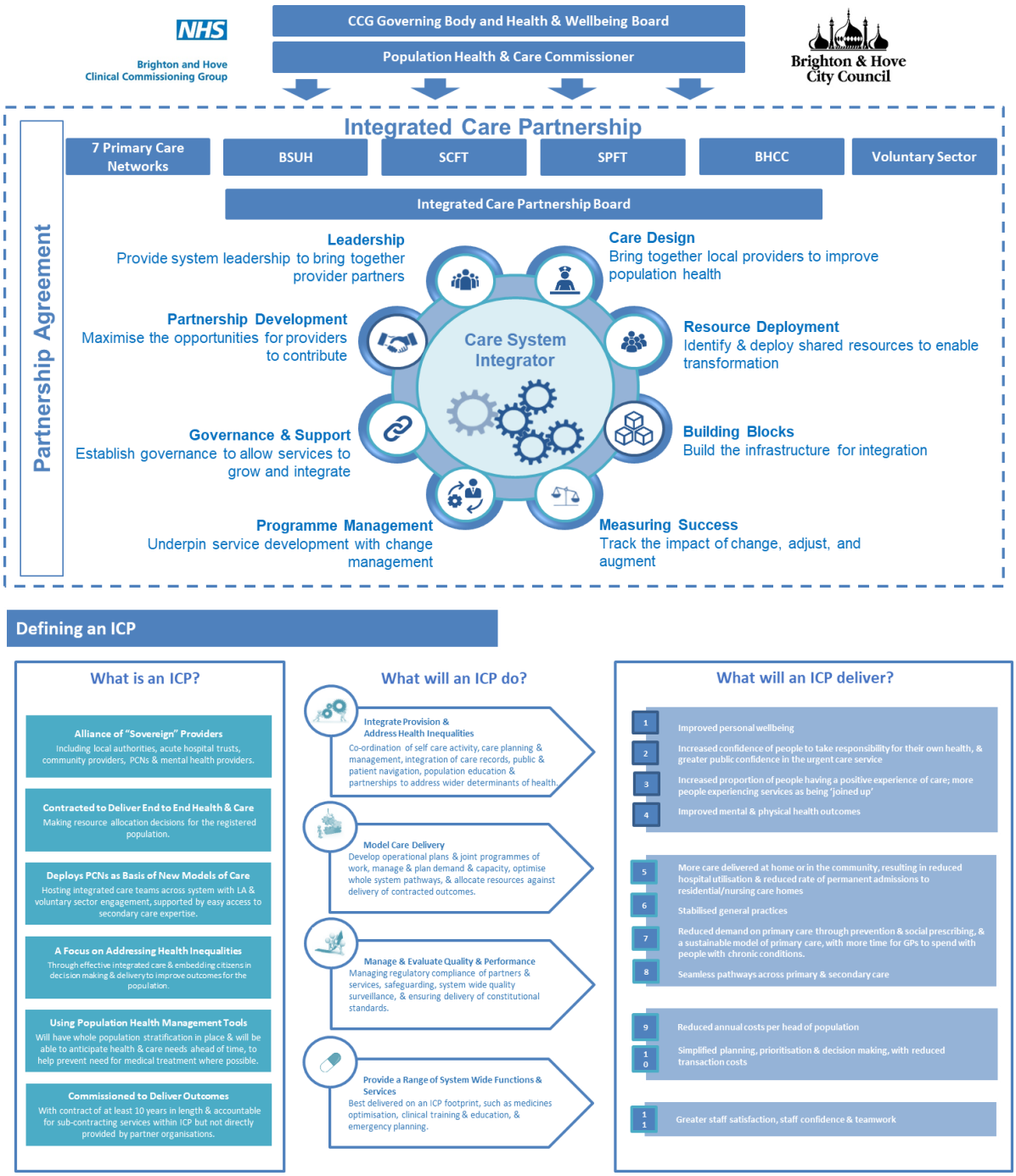


Figure 3: Defining an ICP

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

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

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

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

3.4.1 Primary Care Networks

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

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

A steering group was established to deliver the following objectives:

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

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

An insight into integration within the Goldstone PCN…

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

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

3.4.2 Enablers to integration - data

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

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

3.4.3 Enablers to integration – clinical shadowing

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

The initial five priorities for discussion and work are:

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

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

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

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

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

3.5 Our governance model, programme leadership and resourcing

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

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

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

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

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

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

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

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

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

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

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

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

The immediate next steps for integration are as follows:

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

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

The role of Healthwatch…

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

David Liley, CEO, Healthwatch Brighton & Hove

An insight into our Community Assets…

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

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

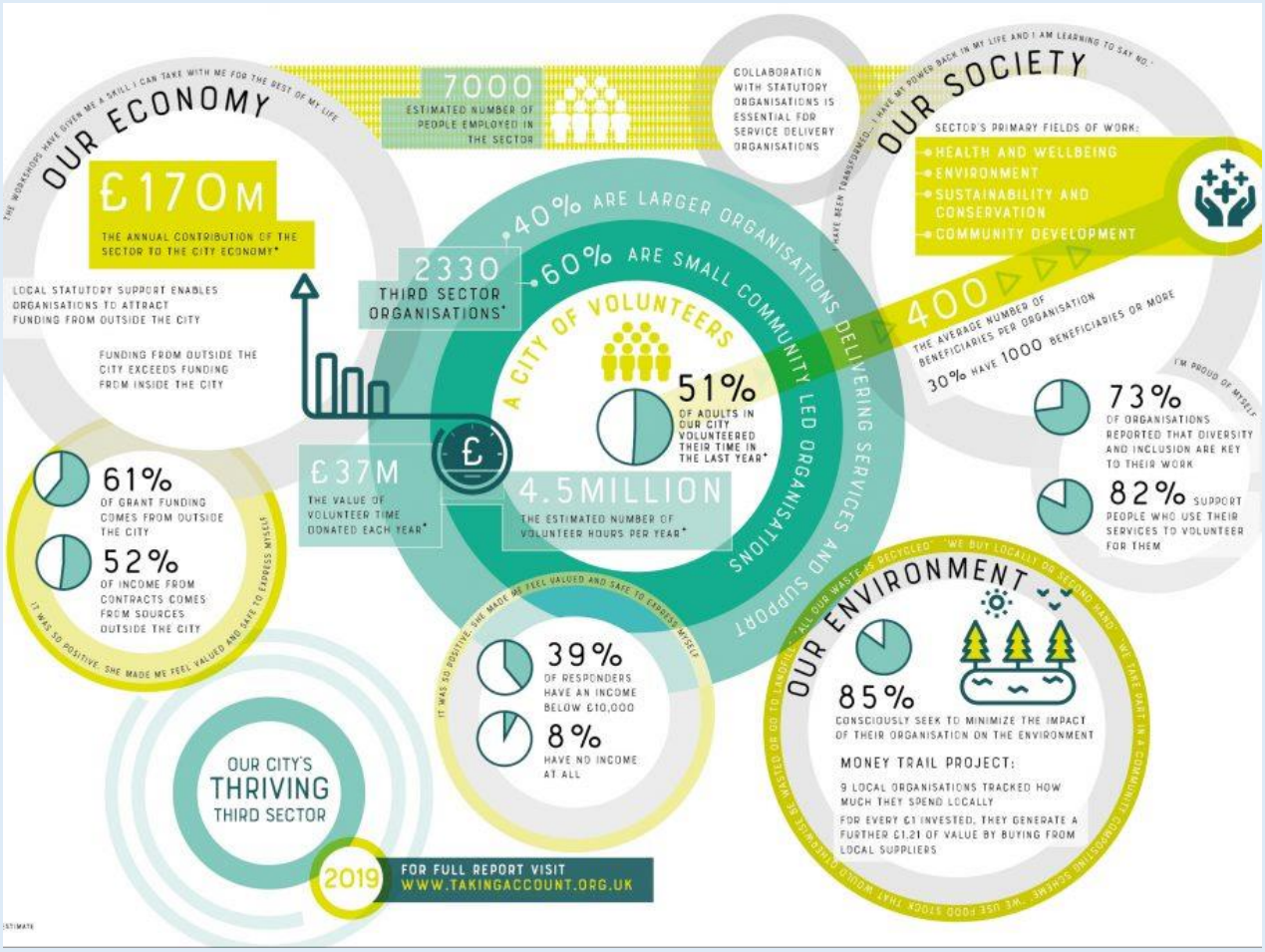


Figure 4: Assets in Brighton & Hove

3.6 System roadmap

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

2019-2020

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

2020-2021

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

2021-2022

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

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

4.1 Starting Well

An insight into how we engage with our young people…

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

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

4.1.1 Integrating children's and young people's services

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

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

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

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

4.1.2 Implementing Sussex wide programmes of work

Mental health

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

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

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

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

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

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

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

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

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

In 2019/2020:

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

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

In 2020/2021 onwards:

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

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

Childhood immunisations

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

Learning disabilities and autism

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

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

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

4.2 Living Well

An insight into how we engage with our People…

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

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

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

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

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

4.2.1 Primary prevention

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

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

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

schools and workplaces to provide healthier environments.

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

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

4.2.2 Planned care

Reducing waits

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

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

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

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

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

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

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

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

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

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

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

Musculoskeletal conditions

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

Patient choice

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

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

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

4.2.3 Transforming outpatients

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

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

An insight into our tele-ophthalmology pilot…

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

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

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

Key outcomes:

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

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

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

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

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

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

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

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

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

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

4.2.4 Respiratory services

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

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

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

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

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

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

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

4.2.5 Personalised care

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

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

Shared decision making

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

Social prescribing

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

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

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

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

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

Personal health budgets

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

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

We will work together to ensure that;

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

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

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

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

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

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

4.2.6 Local priorities: trans locally commissioned service in primary care

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

4.2.7 Implementing Sussex wide programmes of work

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

Mental health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sexual health

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

The service also provides:

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

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

Cancer

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

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

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

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

Key milestones for cancer care locally are detailed as follows:

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

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

An insight into how we work with the CVS…

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

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

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

Diabetes

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

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

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

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

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

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

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

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

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

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

Unwarranted clinical variation

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

4.3 Ageing Well

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

Other core principles included:

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

4.3.1 Transforming out of hospital and community care

Our plans for transformed out of hospital care

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

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

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

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

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

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

The timeline for transformation of out of hospital services is:

2019-2020

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

2020-2021

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

2021-2022

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

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

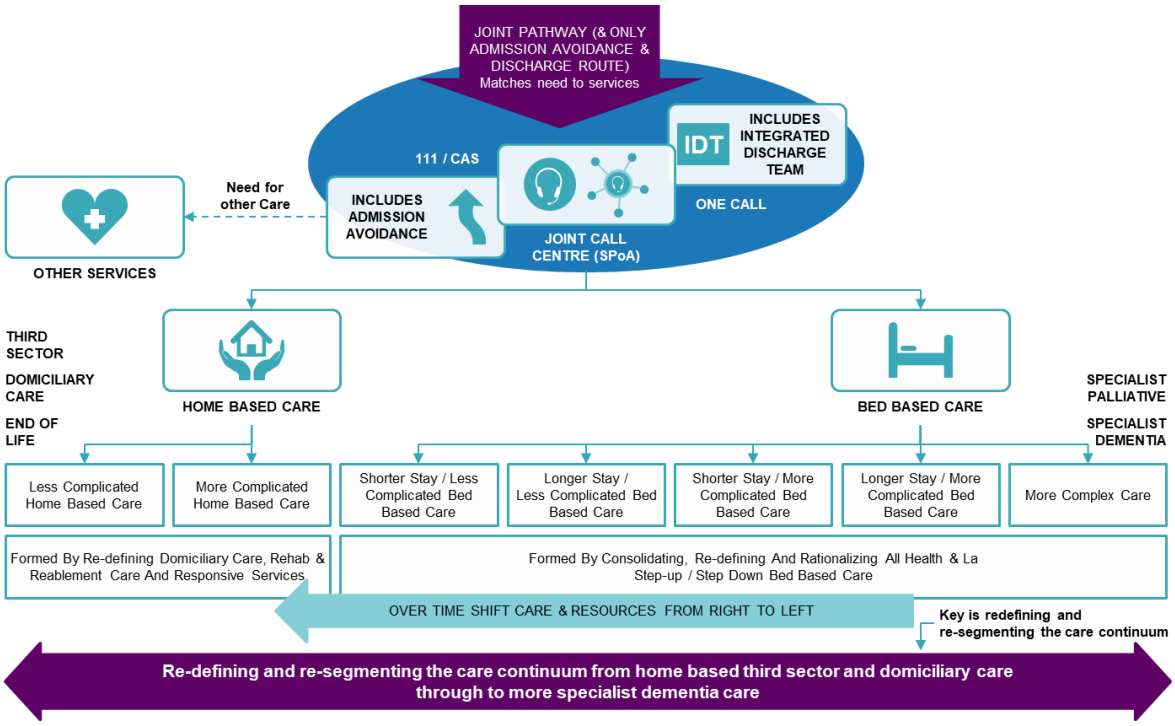


Figure 5: New model of bed-based care

Responsive community services

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

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

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

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

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

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

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

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

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

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

Anticipatory care

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

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

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

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

Enhanced care in care homes

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

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

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

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

Support for carers

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

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

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

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

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

4.3.2 Other local plans to support Ageing Well

Ageing Well service

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

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

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

An insight into the Ageing Well service…

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

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

Comprehensive Geriatric Assessment

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

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

Multiple long term conditions including frailty and dementia

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

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

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

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

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

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

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

4.4 Dying Well

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

The first steps in delivery of this priority are to:

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

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

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

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

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

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

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

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

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

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

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

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

5 Quality

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

Quality assurance and improvement

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

The quality team will work alongside our commissioning teams to:

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

Learning from serious incidents

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

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

Infection prevention

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

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

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

Workforce development

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

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

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

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

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

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

Safeguarding adults, children and looked after children

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

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

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

6. Enablers

6.1 Digital

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

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

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

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

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

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

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

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

6.2 Estates

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

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

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

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

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

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

6.3 Workforce

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

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

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

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

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

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

Reference documents

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

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

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

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

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

Sussex
Health and Care Partnership

East Sussex Place-Based Response to the Long Term Plan



Drafting note: *This draft plan reflects our current understanding of the plans, priorities and next steps for our system, noting that some areas of the plan have already been initiated and some are at an earlier stage of development, programme definition and work up. The contents are being tested across our system and key stakeholders to further scope, shape and agree programme plans for 202021 and beyond to meet the Sussex Health and Care Partnership submission deadline to NHS England of 15th November, and may change as a result.*

DRAFT

East Sussex Health and Social Care Plan

28th October 2019

Draft v5

East Sussex County Council

NHS

Patient-centred
Partnership
Transformation
Sussex
Health
Integration
Sustainability
Social care

Table of Contents

1. East Sussex Health and Social Care Plan 1
   1.1. Introduction and context 1
   1.2. Our population health and social care needs 2
   1.3 . Who we are – our health and care system 4
   1.4. Where we are now 5
   1.5. Where we want to get to 5
   1.6. What we want to deliver 6
   1.7. How we will deliver against the NHS Long Term Plan commitments and local priorities 7
   1.8. Summary of system priorities for 2020/21 8
2. Summary roadmap 12
3. Our approach to engaging with our stakeholders 13
   3.1. Background 13
   3.2. Developing our East Sussex Plan - insight and key themes from recent engagement 13
   3.3. Next steps – testing emerging plans 14
   3.4. Informing ongoing planning and implementation 14
   3.5. Draft summary of key themes from the audit of recent engagement activity in East Sussex
4. Working together to deliver our plans 17
   4.1 Our partnership governance 17
   4.2. Developing our Integrated Care Partnership 18
   4.3. Supporting Primary Care Network development 18
5. Supporting our system to deliver our plans 19
   5.1. Our workforce 19
      5.1.1 Sussex wide developments 19
      5.1.2. East Sussex draft OD Strategy - our strategic vision 20
      5.1.3. Delivering this strategy 21
      5.1.4 Translating the strategy into outcomes for local staff and local people 21
      5.1.5. East Sussex Workforce priorities 21
   5.2 Digital requirements 22
   5.3 Estates requirements 24
      5.3.1. Primary Care premises 24
      5.3.2. Premises Development 24
      5.3.4. Development Status 25
      5.3.5. Acute and community estate 26

DRAFT

Appendices *(Drafting Note: these are in process of being finalised by our system stakeholders and are still subject to change. The complete set will be included in the final draft)*

Appendix 1	Prevention, universal personal care and reducing health inequalities - high level programme description
Appendix 2	Children and Young People - high level programme description
Appendix 3	Community - high level programme descripition
Appendix 4	Urgent Care - high level programme description
Appendix 5	Planned Care - high level programme description
Appendix 6	Mental Health - high level programme description

DRAFT

DRAFT

1. East Sussex Health and Social Care Plan

1.1. Introduction and context

The Sussex Health and Care Partnership (SHACP) is required to submit medium term plans covering the expectations set out in the NHS Long Term Plan (LTP) to NHS England (NHSE). This includes the requirement to "deliver a new service model for the 21st Century", and the transformation and integration plans that will need to be progressed to deliver this. The overarching Sussex-wide submission is a health and care Strategy Delivery Plan covering:

- Sussex-wide plans across specific priority clinical areas, including: Mental Health; Cancer; Prevention; Urgent and Emergency Care; Stroke; Diabetes; Transforming Care Partnership (covering learning disabilities and autism for people with high support needs); Stroke; Diabetes; Maternity, and; reducing unwarranted clinical variation focussing on cardiovascular disease, musculoskeletal conditions and falls and fractures
- Three place plans based on upper tier Local Authority areas - covering East Sussex, West Sussex and Brighton and Hove, outlining our action to deliver NHS LTP commitments and priorities to meet local population health and social care needs
- Sussex-wide plans for workforce, digital and estates
- The finance and activity modelling that will underpin these plans.

Our local East Sussex plan is a joint health and social care plan, which reflects the integrated working in East Sussex and builds on the progress we have made locally and the priorities that we have been working on in 2019/20. Developed in partnership, the plan sets out how we will work together to address both the commitments in the NHS LTP and our local East Sussex priorities by ensuring there is a clear East Sussex health and social care plan to align with, and be part of, the SHACP Strategy Delivery Plan.

This plan has been informed by the national and international evidence base for integrated care to date and our own local development work on our journey towards integration since 2014. We have used benchmarking with tools such as Get It Right First Time, Right Care, and Model Hospital, and a series of recent independent reviews have helped us to further understand the drivers of demand, enabling us to further consolidate our objectives to support improvements to quality of care and the ongoing financial recovery and stabilisation of our system.

Our work on integration to date provides a firm foundation for the next steps as it has piloted and delivered a range of improvements on our journey to a new model of integrated care, including:

- A comprehensive and co-ordinated range of preventative services including; the Healthy Child Programme; One You East Sussex; Making Every Contact Count, Healthy Hastings and Rother, aimed at reducing health inequalities in our most disadvantaged communities; Good Neighbour Schemes; taking forward the Patient Activation Measure and Shared Decision-Making to support greater levels of self-care, and; joint commissioning a range of early intervention and prevention services and support from the voluntary and community Sector (VCS), including support for carers
- Ongoing development of community health and social care services and initiatives, including integrated health and social care teams, crisis response and proactive care, the Dementia Golden Ticket; Health and Social Care Connect now available 24/7, and; the Joint Community Reablement Service

- Strong whole system performance against the Better Care Fund targets and the Care Quality Commission Local Area Review
- Piloting an integrated Outcomes Framework to better enable us to measure whether our work as a system (activity) was having the desired results (outcomes)
- Developing our approach to understanding and using our collective resources on a system-wide basis for the benefit of our population.

Our emphasis in this plan is on the transformation priorities we need to deliver jointly as a health and social care system to meet the future health and care needs of our population. The plan sets out the priorities for programmes of change covering **prevention, community, community, urgent care, planned care and mental health** and how we will work with Primary Care Networks (PCNs), the voluntary and community sector (VCS) and others to support delivery to deliver a "new service model for the 21st century"[1] grounded in the needs of our local population. The plan also describes the local implications for workforce planning, IT and digital and estates.

Our local plan will form the platform for taking forward developing our local Integrated Care Partnership arrangements, as part of the wider development of the Sussex Integrated Care System. In summary our joint plan addresses:

- The NHS LTP commitments by ensuring there is a clear East Sussex plan for our place that also contributes to, and integrates with, the SHACP Strategy Delivery Plan
- The needs of the whole population of East Sussex across physical and mental health, and health and social care services for children and adults from improving health and prevention through to primary and hospital-based care
- A forward view from 2019/20 until 2023/24, taking fully into account the progress made to date and the priorities we have agreed, which are also consistent with the NHS LTP
- The priorities in East Sussex for transformation and integration, and the work in 2020/21 needed to meet the health and care needs of our population and reduce health inequalities, and deliver outcomes on a sustainable basis
- The financial model and infrastructure requirements that will underpin this
- The arrangements for taking forward our Integrated Care Partnership and working with our PCNs, the VCS and wider partners to enable stronger coordiantion of health and care delivery to our population, making best use of our collective resources, and how integrated population health and social care commissioning will be shaped in East Sussex
- How we will build on the comprehensive approaches to engagement undertaken to date and create a framework of continuous engagement with our stakeholders to underpin and inform our plans.

1.2. Our population health and social care needs

East Sussex has a varied and diverse population and is a county with contrasting characteristics across urban and rural communities. There are approximately 555,110 people living in East Sussex. In summary, our population has the following charactersistics and health and care needs:

- The number of young people (aged 0-17) will increase by 3% in the next three years
- The proportion of people over 65 in East Sussex is considerably higher than nationally – 26% in East Sussex compared to 18% in England. By 2023 this will have risen to 27% (19% in England)

[1] NHS Long Term Plan Implementation Framework(July 2019) a copy can be found here

DRAFT

- The proportion of those aged over 85 is already significantly higher in East Sussex than nationally and will continue to rise sharply. It is this group that are the most likely to need our services
- Health and its determinants are not distributed evenly across the county, with a strong link between poverty and poor outcomes; rurality can also impact access to services
- The number of children in need of help and protection is rising locally and nationally, linked to the increase in families experiencing financial difficulties
- There is a growth in the numbers of children with statements of SEND or Education Health and Care Plans, some of whom will have complex medical and care needs
- Demand for health and social care will continue to increase, both as a result of the growth in the proportion of older people in the population and the complexity of their needs with increasing longevity, frailty and multi-morbidity; on average men spend the last 15.5 years of life in poorer health, while women spend 20.2 years in poorer health
- There is a clear gap in life expectancy between people who live in the most and least deprived areas of the county; this gap is 7 years for men and 4.3 years for women while ward level differences are even greater.

In summary, East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country. Within this, many people live their later years in ill-health, often with more than one long term condition, and this is driving increasing demand and pressure on health and care services and resources. Reducing health inequalities and the gap in life expectancy in the county requires coordinated action with services that impact on the wider determinants of health, such as housing, employment and leisure, as well as targeted approaches to empower people to make healthy choices across the whole life course to improve outcomes.

In the long term, for services to be sustainable for everyone who needs them, there is a need for a new model of care to proactively support the older and frail population, and those with multiple long term conditions, through a strong infrastructure of responsive, coordinated and integrated services delivered in communities. This needs to work with people's strengths to help them feel in control of their conditions with easy access to support from health and social care professionals in multi-disciplinary teams when it is needed. Personalised care, shared decision-making with clinical and care professionals and support to self-manage conditions, for example, through the innovative use of digital are all features of a new model of care for the 21st Century.

The advent of PCNs with a focus on proactively managing population health and better anticipating care needs, and integrated working across health and social care, will enable us to deliver the best possible outcomes for local people, and achieve the best use of collective public resources in East Sussex. There is a strong national and international evidence base that demonstrates the value of integrated working in improving patient and client experience and outcomes, as well as better value for money. Overall this will help to moderate demand for hospital services, protecting them so they are available when they are most needed by our population.

The information about East Sussex that has been used to understand our population health and care needs and the priorities for East Sussex can be found in the following documents:

East Sussex Joint Strategic Needs Assessment
http://www.eastsussexjsna.org.uk/
Director of Public Health Report 2018/19
http://www.eastsussexjsna.org.uk/publichealthreports

State of the County 2019, Focus on East Sussex' (July 2019)
https://www.eastsussex.gov.uk/yourcouncil/about/keydocuments/stateofthe-county/

Supporting People to Live Well in East Sussex', the market position statement for adult services and support (April 2019)
https://www.eastsussex.gov.uk/media/13531/market-position-statement-2019.pdf

Sussex and East Surrey Sustainable Transformation Partnership Population Health Check
https://www.seshealthandcare.org.uk/2019/02/population-health-check-published-across-the-stp/

1.3. Who we are – our health and care system

The diagram below shows the health and care organisations who work together to deliver health and care in East Sussex across primary, community, acute, mental health and social care and housing, and the wide range of services and assets we have in our communities that impact on people's health and wellbeing.

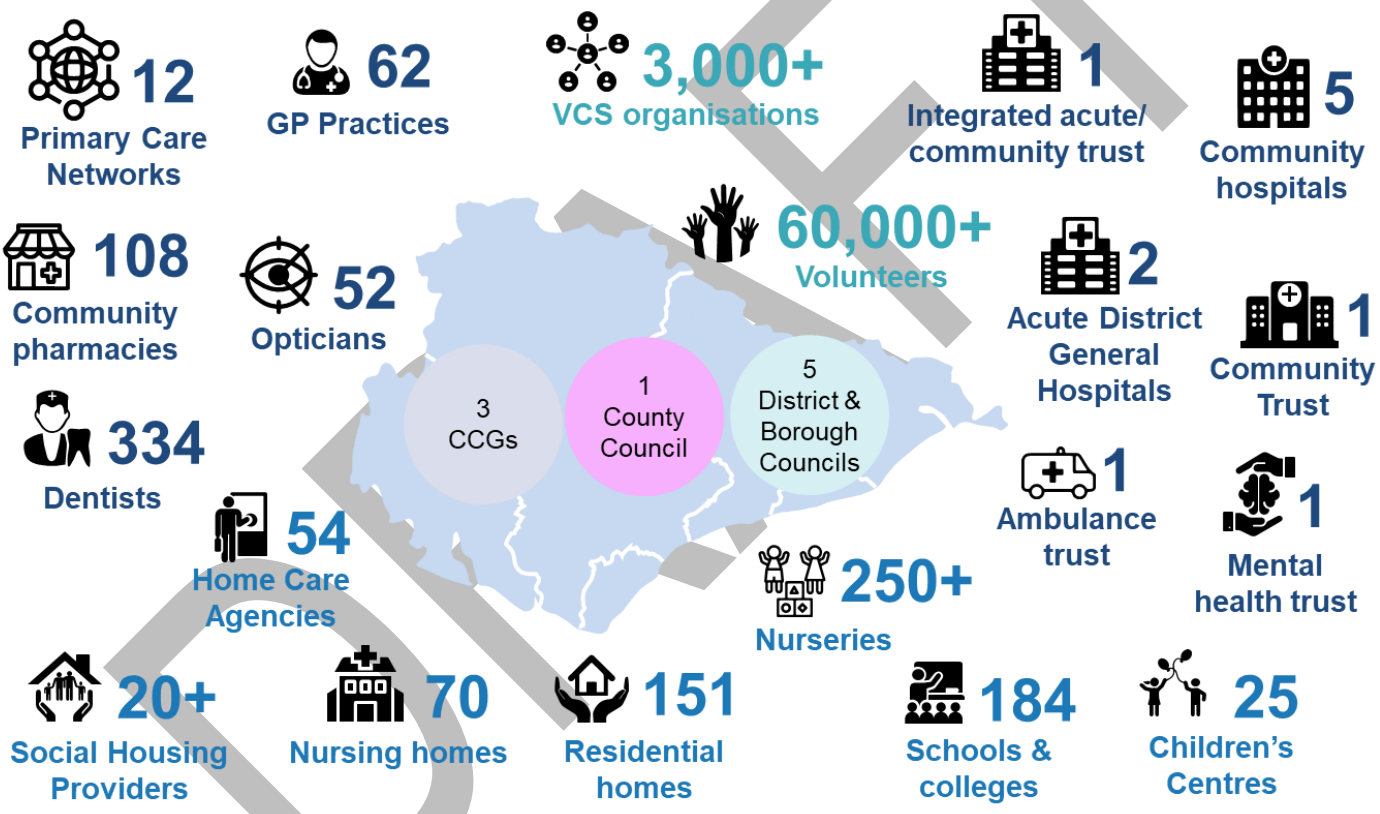


Figure 1: Health and Care organisations in East Sussex

Some of our population accesses hospital-based care outside of East Sussex, and we will work with partners outside of the East Sussex system, for example providers, Primary Care Networks, other Integrated Care Partnerships, STPs and Integrated Care Systems as they emerge, to support integrated care for our population.

1.4. Where we are now

The longer term overarching outcomes we have been working towards in East Sussex are improving population health, improving the quality and experience of care, and improving the financial sustainability of services. In recent years we have progressed our integrated working in East Sussex through two programmes; East Sussex Better Together (ESBT) and Connecting 4 You (C4Y). From 2019/20 we have agreed to bring these two programmes together to provide the foundation for a single East Sussex Health and Social Care Programme.

During the latter part of 2018/19 and early 2019/20 we have taken steps as a system to secure agreement for the following:

- Bringing together our two East Sussex programmes (C4Y and ESBT) into a single programme for health and social care integration covering our whole population
- Developing a joint East Sussex longer term plan for integration to take us beyond our immediate programme priorities in 2019/20, to address both local East Sussex health and social care priorities and delivering the NHS LTP
- Putting in place partnership governance arrangements for our system to support this work, including reinforcing the system oversight role of our Health and Wellbeing Board (HWB). It is expected that this governance will evolve further as we move into the next phase of our plan and programme
- Taking forward a proposal for our three East Sussex Clinical Commissioning Groups (CCGs) to merge into a single CCG for East Sussex (subject to application and approval by NHS England)
- In the context of the SHACP ambition to become a Sussex Integrated Care System (ICS):
    - Developing integrated population health and care commissioning within East Sussex, as part of the wider strategic commissioning function of the SHACP
    - Developing an Integrated Care Partnership (ICP) in East Sussex to support integrated delivery of health and social care, mirroring our population health and care commissioning footprint.

1.5. Where we want to get to

Our immediate programme and organisational priorities for 2019/20 reflected the continued need for grip on financial recovery; reducing pressure on hospital service delivery; improving community health and social care responsiveness, and; ensuring good use of, and shorter waits for, planned care. This was achieved through consolidating the financial recovery work and ESBT and C4Y objectives into a single programme with priorities for the next 6-12 months across urgent care, planned care and community.

Alongside delivery of 2019/20 plans our key priority in East Sussex has been to develop a longer term plan. This will enable health and social care in East Sussex to describe our next steps, building on the plans that are currently being implemented. Aligned to the SHACP Strategy Delivery Plan, the plan strengthens the whole population focus across the East Sussex health and social care economy, as well as inform the priorities and plans for 2020/21.

In summary, our East Sussex Plan is a joint health and social care plan that builds on what has already been delivered, to produce an up to date statement about our joint programme and integration plans for the next three to five years, covering:

1. The needs of our whole East Sussex population and the outcomes required to meet them

DRAFT

2. Our plans for driving the transformation and integration required to meet population health and care needs, reduce health inequalities and deliver longer-term sustainability, including our priorities for 2020/21
3. The finance and activity modelling that will underpin this across the next three to five years
4. The development of our East Sussex Integrated Care Partnership (ICP) and integrated delivery with our Primary Care Networks (PCNs), with integrated population health and care commissioning arrangements.

1.6. What we want to deliver

Informed by our local East Sussex County Council priorities[2] and NHS Long Term Plan[3,4] commitments, and engagement with our local communities, we expect to build on our integration work to date to deliver:

- A comprehensive approach to prevention, universal personal care and reducing health inequalities that cuts across our key clinical priorities and care pathways from supporting healthy lifestyles and wellbeing, greater levels of self-management, shared decision-making, and personalised care and support planning, through to early intervention, proactive care and reablement
- Full implementation of a common operating model for integrated community health and social care, working with PCNs and the VCS to jointly deliver greater community health responsiveness in 2020/21, including:
  - Improved crisis response within two hours and reablement care within two days
  - Anticipatory care
  - Enhanced Health in Care Homes
  - Structured medication review for priority groups
  - Personalised care and support planning, and early cancer diagnosis support
  - Social prescribing and community-based support
  - Better identification and support to improve outcomes for carers
  - The continued implementation of Extended Access in 2019/20 and 2020/21
  - Building the capacity, workforce and partnerships to do this
- A description of our financial model from 2020/21 to 2023/24 that demonstrates the shift in investment to primary care and community health care, including meeting the new primary medical and community health services funding guarantee
- Close system working between our East Sussex CCGs, East Sussex County Council, East Sussex Healthcare NHS Trust, Sussex Partnership NHS Foundation Trust, Sussex Community NHS Foundation Trust, and our local PCNs, to ensure that Sussex-wide strategies and developments align with our local plans for integrated community health and social care and a comprehensive approach to prevention, universal personal care and reducing health inequalities
- Close system working across the local NHS and children's social care to deliver ESCC and NHS LTP priorities to ensure age-appropriate integrated care; integrating physical and mental health services; joint working between primary , community and acute services, and; supporting transition to adult services
- The continued implementation of our urgent care plans to reduce pressure on emergency hospital services including:

[2] 'State of the County 2019, Focus on East Sussex' (July 2019), a copy can be found here
[3] NHS Long Term Plan (January 2019), a copy can be found here
[4] NHS Long Term Plan Implementation Framework(July 2019) a copy can be found here

DRAFT

- Meeting the A&E standard and agreed metrics for Same Day Emergency Care, and urgent and emergency care
- Implementation of our integrated urgent care model and an integrated network of community and hospital-based care
- Implementing Urgent Treatment Centres by December 2019
- Implementing the new 111 and Clinical Assessment Service (CAS) by April 2020

- The continued implementation of our planned care programme including:
  - Increasing elective care activity to reduce elective waiting lists
  - Enabling choice through expanding digital and online services
  - Digitally enabling primary and outpatient care through the increased use of digital tools to transform how outpatient services are offered, and providing more options for virtual outpatient appointments in identified priority specialties, working with the Sussex Outpatient Transformation Board
  - Scaling up provision of First Contact Practitioners to enable faster access to diagnosis and treatment for people with musculoskeletal conditions and supporting more patients to effectively self-manage their conditions
- Proposals for implementing our East Sussex **Integrated Care Partnership** model to better enable delivery of these principles and priorities, as part of the wider development of the SHACP Integrated Care System.

1.7. How we will deliver against the NHS Long Term Plan commitments and local priorities

Our local East Sussex work on integration and transformation to date aligns well with expectations set out in the NHS LTP and Implementation Framework. We have undertaken analysis that captures how we anticipate delivering commitments in the NHS LTP and our local priorities. This is being used to inform:

- Our individual organisational corporate strategies and operational business planning processes for 2020/21 and beyond, and the partnerships, programmes and projects through which we will deliver improvements to the quality of care
- Alignment with the SHACP Strategy Delivery Plan clinical priorities and plans to support local implementation and delivery, including Sussex-wide strategies for workforce, digital and estates.

In addition, the LTP commitments have been consolidated with our local understanding of the priorities and objectives for our system to date, and the evidence base arising from diagnostic work in 2018/19 on the drivers of our system deficit at that time, and benchmarking tools such as Model Hospital, Get it Right First Time and NHS Right Care. This has given us a set of key priorities we need to focus on as a system in 2020/21, to drive the changes needed to meet the health and care needs of our population sustainably in the coming years. The priorities will be used to set objectives and Key Performance Indicators (KPIs) for our work programmes in 2020/21, and our Health and Wellbeing Board and supporting system partnership governance will oversee delivery.

The priorities reflect our current understanding of the plans and next steps for our system, noting that some areas of the plan have already been initiated and some are at an earlier stage of development, programme definition and work up. This will continue to be tested across our system and key stakeholders to further scope, shape and agree programme plans for 202021 and beyond. Fundamental to this will be co-design and co-production of projects and initiatives with patients, clients and carers to ensure that pathways are informed by lived experience.

There are strong links between all the programme areas and changes in one area may have benefits for others. For example, work under the community strand aimed at increasing capacity and efficiency, will enable improved patient flow through hospital and reduced length of stay as

DRAFT

well as improved outcomes for people and their families. Likewise, plans for prevention and personalised care are cross-cutting and elements, will be delivered through linking up priorities across the programme.

The overarching key priorities across prevention, community, urgent care, planned care and mental health are summarised below, and further detail about each area is set out in the Appendices.

Drafting Note: *the Appendices are in process of being finalised by our system stakeholders. The complete set will be included in the final draft to meet governance timetables.*

1.8. Summary of system priorities for 2020/21

1.8.1 Prevention priorities

To support a comprehensive approach to prevention, universal personal care and reducing health inequalities, in addtion to ongoing work on specific activities such as smoking, obesity and alcohol, the following next steps are suggested:

- Use national guidance to set trajectories for narrowing inequalities in 2023/24 and 2028/29 to inform local wider system action planning
- Deliver PCN Network Contract requirements for population risk stratification in 2020/21 to develop a targeted approach to managing population health, and link this with:
    - wider system partnership action to reduce health inequalities, including the further development of Social Prescribing pathways and community-based support in 2020/21 to support mental health and wellbeing
    - the Patient Activation Measure (PAMS) pilot review to inform further development of self-care and self-management
- Ensure that prevention, self-care and self-management, shared decision-making, and personalised care and support planning approaches are built in to identified planned care pathway developments in 2020/21, as appropriate, using NICE guidance and other available condition-specific tools
- Build on the rollout of wheelchair Peronal Health Budgets to identify further cohorts of patients for Personal Health Budgets/integrated personal budgets starting with Continuing Healthcare
- Build early intervention, proactive care and reablement focussed aftercare as key features of our developing common operating model for community health and social care services.

1.8.2 Children and Young People priorities

To take forward close system working and ensure age-appropriate integrated care across physical and mental health services; joint working between primary, community and acute services, and; supporting transition to adult services, we are scoping four key priorities for transforming children and young people's services:

Improving children and young people's mental health and emotional wellbeing

- Improving our pathways and commissioning approach particularly with regard to Tier 4/ Secure/Specialist placements
- Developing a coherent Emotional wellbeing strategy which works with our schools to provide appropriate help at the earliest point

Disability Pathways

DRAFT

- Further develop our work around integrating the Education, Health, and Social Care needs of Children and Young People, aimed at producing local solutions.

Safeguarding (including Contextual Safeguarding)

- Further develop our pathways and service offer for young people at risk of criminal and sexual exploitation, physical and sexual harm, alcohol and substance misuse.
- Ensure links into the mental health and wellbeing priority.

Universal Child Health Offer

- Ensure the provision of the Healthy Child Programme for under 5s through the Integrated Health Visiting and Children's Centres service
- Support the preventative health agenda through School Health Service.

1.8.3 Community priorities

Our ongoing focus for the services we provide in people's homes or in the community is to build capacity and clearer pathways for people accessing services, and the support we provide to people after they leave hospital. To enable greater levels of multi-disciplinary working across primary medical care and community health and social care services, work in 2020/21 will centre on the continued implementation of integrated community health and social care and supporting the Network DES Contract specification for PCN development in 2020/21.

Implement Integrated Community Health and Social Care

- Continue to deploy home-based and bed-based Homefirst pathways
- Continue to pilot and roll out co-location and care coordination for those with multiple long term conditions
- Take forward therapy joint working to share skills, best practice and help create capacity
- Develop, agree and implement a common target operating model to support multi-disciplinary working across primary, community health, mental health and social care for 2020/21, taking into account any differences due to local circumstances and evidence, for example, due to patient flows in and out of the county
- Align with pathways for acute hospital (ESHT) Integrated Discharge Team.

PCN Network DES Contract implementation for 2020/21

- Delivery of risk stratification to enable proactive anticipatory care for those with multiple long-term conditions
- Wider development and roll out of Enhanced Care in Care Homes.

1.8.4 Urgent Care priorities

Working with partners across primary care and South East Coast Ambulance Service NHS Foundation Trust, the key focus of the Urgent Care programme is to transform urgent and emergency care services in East Sussex to ensure that, in an emergency, people are treated in the most appropriate place by the right clinical and/or social care service. The priorities are closely aligned with the SHACP plans for Urgent and Emergency Care and include a mix of work to implement Urgent Treatment Centres (UTCs) and local priorities which support ongoing financial recovery and stabilization:

High Intensity Users

DRAFT

- Focus on supporting patients with multiple needs with high numbers of A&E attendances and admissions.

Ambulatory Urgent Care

- Expansion of Ambulatory Emergency Care at both Eastbourne District General Hospital (EDGH) and Conquest Hospital
- Supporting Same Day Emergency Care.

Acute frailty

- Expansion of Acute Frailty teams and pathways to ensure the right support at the front door
- Supporting Same Day Emergency Care.

Enhanced Care in Care Homes

- Implementation of ward rounds to better support patients in care homes, build confidence for staff and avoid unnecessary admissions.

Community Frailty/PEACE planning

- Further rollout of Frailty Practitioner-Led Personalised Advisory Care (PEACE) planning as part of care planning roll-out; supporting cohort of patients in care homes.

Integrated Urgent Care

- Rollout of enhanced NHS 111 and Clinical Assessment Service from 1st April 2020
- Rollout of Urgent Treatment Centres at EDGH, Conquest Hospital and Victoria Hospital
- Direct booking into Improved Access and Walk In Centres
- Increased utilisation of Improved Access capacity.

In addition, the Local A&E Delivery and Urgent Care Oversight Board are in the process of analysing the key drivers of demand behind the recent increases in A&E attendance and admissions to scope further interventions to take forward in winter 2019/20 and 2020/21.

1.8.5 Planned Care priorities

The following areas of focus are suggested to continue transforming our care model, to ensure that those who are referred into hospital are seen and treated as quickly as possibly:

Evidenced Based Interventions - maintain the GP Referral rate for East Sussex in the upper quartile of Sussex Health and Care Partnership

- Further mature GP Referral pathways to make best use of resuorces and time across our system
- Ensure all new processes sustainable and embedded and automatically alert when trending towards an outlier

Outpatients Redesign - offer video outpatient appointments in two specialities

- Pilot technology with most beneficial specialties

Musculoskeletal Services (MSK) - community services meets demand and constitutional waiting standards

DRAFT

- Review MSK community and primary care workforce activity and demand
- Redesign workforce aligning with SHACP MSK, including first contact practitioners, to provide faster diagnosis and treatment
- Review pain management services.

Cancer performance meets constitutional waiting times

- Work with PCNs to improve the uptake of screening targeting those areas with lower uptake and focus on inequalities.
- Develop diagnostics working towards set up of the rapid diagnostic service.
- Continue to ensure implementation of timed pathways so support earlier diagnosis and treatment.
- Ensure personalised care pathways in breast cancer are implemented and plans for other specialties are developed, with prostate and colorectal as priorities for 2020.

East Sussex future Cardiology Care Model agreed, implementation plans approved and resources allocated

1.8.6 Mental Health priorities

Our system work on mental health takes place in the context of the Sussex Health and Care Partnership Mental Health Programme priorities, and the local implementation necessary to support closer system working between physical and mental health, community health and social care, and primary care. The following areas are suggested for further exploration, scoping and shaping the programme of work in East Sussex:

- Single point of access - no 'wrong doors' and access to crisis pathways
- Supporting people in the community through community health and social care teams for adults with severe mental health issues
- Supported Accommodation pathways
- Aftercare and support
- Access to children and young people's mental health services.

1.8.7 End of Life Care

Strategies are in place across East Sussex with the aim of ensuring that high quality, individualised end of life care is effectively coordinated and integrated and provided to all those who need it, regardless of diagnosis or age. This can include ensuring conversations take place about death and dying at an early stage, and supporting people to make plans and communicate these with those who are important to them. This care should extend beyond death to include bereavement and support for families. Plans guiding the full implementation of this approach have been taken forward in 2019/20 and these will need to be continued into 2020/21. The **overall aims** are to:

- **Improve the quality** of end of life care for people in East Sussex by **coordinating care** and integrating pathways and services where possible
- **Improve access** to individualised end of life care, by improving identification of people in their last year of life and having conversations about death and dying early and recording these for use by the whole system
- **Improve palliative care through the identification** of those living with life limiting conditions and providing appropriate services for individuals and their families
- **Improve the skills, confidence and capability** of those who care for people at the end of life by providing training and learning opportunities to staff across the whole health system including non-NHS carers.

Further detail is included in Appendix 5 (*to be added*) – high level programme priorities for planned care.

2. Summary roadmap

The key milestones for the next five years are:

August – November 2019	East Sussex Health and Social Care Plan development, including: • Further refinement of priority-setting, and transformation programme objectives for 2020/21 • Refresh of integrated Outcomes Framework • Testing with local system and stakeholders • Developing proposals for our Integrated Care Partnership for the delivery of health and social care for East Sussex • Developing proposals for the approach to integrated population health and care commissioning in East Sussex • Final submission of the SHACP NHS Long Term Plan Strategy Delivery Plan to NHS England (Sussex-wide plans and place plans for delivering NHS LTP commitments)
December 2019	• Health and Wellbeing Board endorses East Sussex Health and Social Care Plan, including: ○ Transformation programme priorities and objectives for 2020/21 ○ Proposals for taking forward the Integrated Care Partnership ○ Proposals for taking forward population health and care commissioning
January – March 2020	• Further implementation planning for 2020/21
April 2020	• East Sussex Clinical Commissioning Groups merger complete, subject to application and approval by NHS England
April 2020 – March 2021	• Delivery of 2020/21 transformation programme and LTP priorities • Further implementation (as per agreed proposals) of: ○ East Sussex Integrated Care Partnership ○ East Sussex Population Health and Care Commissioning ○ Target common operating model for community health and social care services • Delivery of next wave of PCN Network Contract DES requirements, including: ○ Anticipatory Care ○ Enhanced Care in Care Homes • Continued financial stabilisation of system
April 2021 – March 2022	• East Sussex Integrated Care Partnership in place • East Sussex Population Health and Care Commissioning in place • Sussex Integrated Care System in place • Continued financial stabilisation of system
April 2022 – March 2023	• Consolidation of our Integrated Care Partnership and population health and care commissioning arrangements

DRAFT

	• Continued financial stabilisation of system
April 2023 – March 2024	• Primary medical and community health service funding guarantee met

3. Our approach to engaging with our stakeholders

3.1. Background

A comprehensive approach to engagement with patients, clients, our staff, the public and communities across East Sussex has been a strong feature of our health and social care transformation programmes to date. This has been undertaken in partnership with Healthwatch and the Voluntary and Community sector (VCS) and is taken forward at all levels – including representation in strategy and planning, and using co-design principles to involve people in the commissioning of specific services, service design and project development.

Overall strategy has been guided and supported by our East Sussex Communications and Engagement Steering Group which brings together communications and engagement leads from across our health and social care partner organisations, including Healthwatch.

Our approach has also been partly underpinned by the development of an integrated Outcomes Framework in 2017/18, based on what is important to local people about their health and care services. This is collectively owned and shared across our health and social care system. We aim to widen the scope of this Outcomes framework as part of our planning process to ensure it truly reflects the whole East Sussex population.

East Sussex was also involved in the Sussex Health and Care Partnership's wide ranging public engagement exercise about the NHS Long Term Plan during the Spring of 2019 – the Big Health and Care Conversation, culminating in the report 'Our Health and Care, Our Future'. This was a programme of engagement that took place across the whole of Sussex, in partnership with Healthwatch, and included events and online surveys. Detail is provided below about how this information has been used to inform and contribute to developing our East Sussex Plan.

3.2. Developing our East Sussex Plan - insight and key themes from recent engagement

A multi-agency East Sussex Plan Task Group has been set up with nominated leads across our system, including representation from Healthwatch and the Voluntary and Community Sector. The Task Group has met twice to scope the work and produce a development framework to guide the programme of work. Additional meetings have taken place to progress work with a range of leads from organisations across public health and prevention, community, urgent care, planned care, mental health, children's social care, finance, workforce and communications and engagement.

The following work has helped inform and contribute to the development of our East Sussex Plan over the summer:

- An audit of existing insight from recent engagement events and exercises to provide a snapshot of the key themes across East Sussex. This included harvesting the East Sussex insight from the Phase 1 report from the Big Health and Care Conversation and Our Health and Care, Our Future engagement on the NHS LTP (Phase 2 will be added when

DRAFT

available), as well as from the joint Shaping Health and Care events that are specific to East Sussex

- The themes from the audit have been used to help inform the key principles and priorities for our East Sussex Plan, and will continue to be used to help inform our planning and priority setting in the coming weeks. The draft summary of the key themes from the audit is included at the end of this document
- The themes from the audit are also being used as a guide to what matters to people living across East Sussex, as part of updating our integrated Outcomes Framework for 2020/21 and ensuring it continues to be based on what matters to local people about their health and social care services

3.3. Next steps – testing emerging plans

We will further test the key principles and priorities of our East Sussex Plan, and the updates to our integrated Outcomes Framework with our local stakeholders during October and November, ahead of the final draft Plan being brought to the East Sussex Health and Wellbeing Board (HWB) for endorsement in December 2019. This will be done through existing mechanisms such as the Patient Participation Groups Forum, the East Sussex Seniors Association (ESSA), and the East Sussex Inclusion Advisory Group (IAG). These will also align with engagement being coordinated by the SHACP on the Strategy Delivery Plan, supported by a digital approach to make sure we are reaching our broad base of stakeholders who we are regularly in touch with about developments.

Plans are in place to undertake a high level joint Equalities and Health Inequalities Impact Assessment (EHIA) screen of our East Sussex Plan, with a view to flagging potential areas where future EHIAs will be needed for specific projects and initiatives. This will inform the framework for continuous engagement with all of our stakeholders.

3.4. Informing ongoing planning and implementation

Building on the comprehensive approaches to engagement undertaken to date, the priorities and next steps for transformation and integration that come out of the planning process for the East Sussex Plan will be used to create a framework of continuous engagement with our stakeholders. This will underpin and inform our ongoing system communications and engagement activity in the coming months.

Our system partnership governance has been reviewed and has evolved to ensure a broader system partnership to oversee delivery of the East Sussex Plan and development of our Integrated Care Partnership proposals on behalf of the HWB, through aligning organisational plans across our health, social care and wellbeing system and involving all key stakeholders. More information about this can be found in section 4.

We have recently entered into a new arrangement to strengthen the involvement of voluntary and community partners. The new East Sussex ‘Partnership Plus’ forum brings partners together to take a different approach to how we work together and more effectively use our combined resources, build on existing skills and knowledge and develop much better ways of working for the benefit of people in East Sussex. A joint planning group has been formed to get things moving to identify community priorities, using our collective knowledge and data and move swiftly to “doing” – taking in action on the wider determinants of health as well as the role of the VCS in delivering health and care services and support.

DRAFT

3.5. Draft summary of key themes from the audit of recent engagement activity in East Sussex

Theme	Which reports?
Joining up health and care services, partnership working and collaboration • People told us we needed to have better co-ordination across the health and care system in order to improve people's experience of receiving services and make the system less confusing (pathways, information sharing, joined up working). They talked about the importance of partnership working and involving the right people and organisations, the ongoing challenges to integration, the importance of collaboration and co-design – for example involving Patient Participation Groups (PPGs) in commissioning. In the OH&COF engagement people fed back that the creation of multi-disciplinary 'Health Hubs' was a great opportunity	• Healthwatch • OH&COF[5] • SH&C[6] Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation • Listening To You
Communication, access to information, and information sharing • People consistently told us we need to improve access to information, and improve communication about services, between staff, between organisations and to patients about their care. People told us we need to have integrated IT systems and record sharing, but that we should consider confidentiality and how people's information is used.	• Healthwatch • OH&COF • SH&C Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation • Listening To You
Digital • People gave positive feedback about increasing use of digital services and innovations, and that it could help make best use of resources. They also said we must ensure we don't exclude people who may not be able to access digital services.	• OH&COF • SH&C Spring '18 • SH&C Autumn '18
Staffing, resources and funding • People acknowledged increased demand for care and appreciate honest conversations, but also emphasised the importance of having more/enough staff, that resources must be adequately planned for the future and for the population (for example where there is new housing), and gave views on where they thought resources should be directed and how to make best use of existing staff. There is sometimes a mismatch between what people feel they need and what the system is offering. The need for more GPs was a common theme.	• Healthwatch • OH&COF • SH&C Spring '18 • Big Health and Care Conversation • Listeing To You
The role of the voluntary and community sector, and social prescribing • The importance and value of the voluntary and community sector and social prescribing was highlighted throughout the engagement, and people said that it should be adequately planned	• Healthwatch • OH&COF • SH&C Autumn '18

[5] Our Health and Care Our Future

[6] Shaping Health and Care

DRAFT

Theme	Which reports?
and resourced. People taking part in the Healthwatch mental health focus groups said VCS organisations are picking up services no longer provided by the statutory sector.	• Big health and Care Conversation
Health inequalities • People agreed that there shouldn't be ''postcode lotteries'' for care, and said that there are still significant health inequalities to address. The issue of transport and access for rural communities was raised consistently.	• Healthwatch • OH&COF • Big Health and Care Conversation
Behaviour change and prevention • People are aware of, and agree with, the importance of their own choices in living healthy and independent lives, but said that the healthcare system and staff also play an important role in prevention. People said access to information, education, services and facilities is important, alongside addressing barriers to access.	• Healthwatch • OH&COF • SH&C Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation
Mental health • Issues raised around mental health services include access, waiting times, support to meet people's needs, communication with people about their care. Support for those with autism and dementia was also discussed in connection with mental health • Issues raised around young people's mental health services include access to services and experience.	• Healthwatch • OH&COF • Big Health and Care Conversation
Holistic and personalised care • People highlighted the importance of a holistic approach and more personalised care, including ''non-medical'' solutions, a joined up system, and support from healthcare professionals to help them make their own or joint choices.	• Healthwatch • OH&COF • Big Health and Care Conversation
Access to services and experience of services • There was lots of feedback about difficulty accessing services or not feeling they are getting enough support. For example, lack of co-ordination in the system, availability and timeliness of appointments, availability of GPs/ HCPs or treatment, continuity of care and gaps in services, and home care provision. As above, support for young people's mental health needs was also a common point of feedback.	• Healthwatch • OH&COF • SH&C Spring '18 • Big Health and Care Conversation • Listening To You
End of life care • People highlighted the importance of better conversations and support around end of life care, including conversations with their GP.	• Healthwatch • OH&COF • Big Health and Care Conversation
Multiple and complex needs • People with multiple or complex needs find it more difficult to access the support that they need.	• Healthwatch • OH&COF

DRAFT

4. Working together to deliver our plans

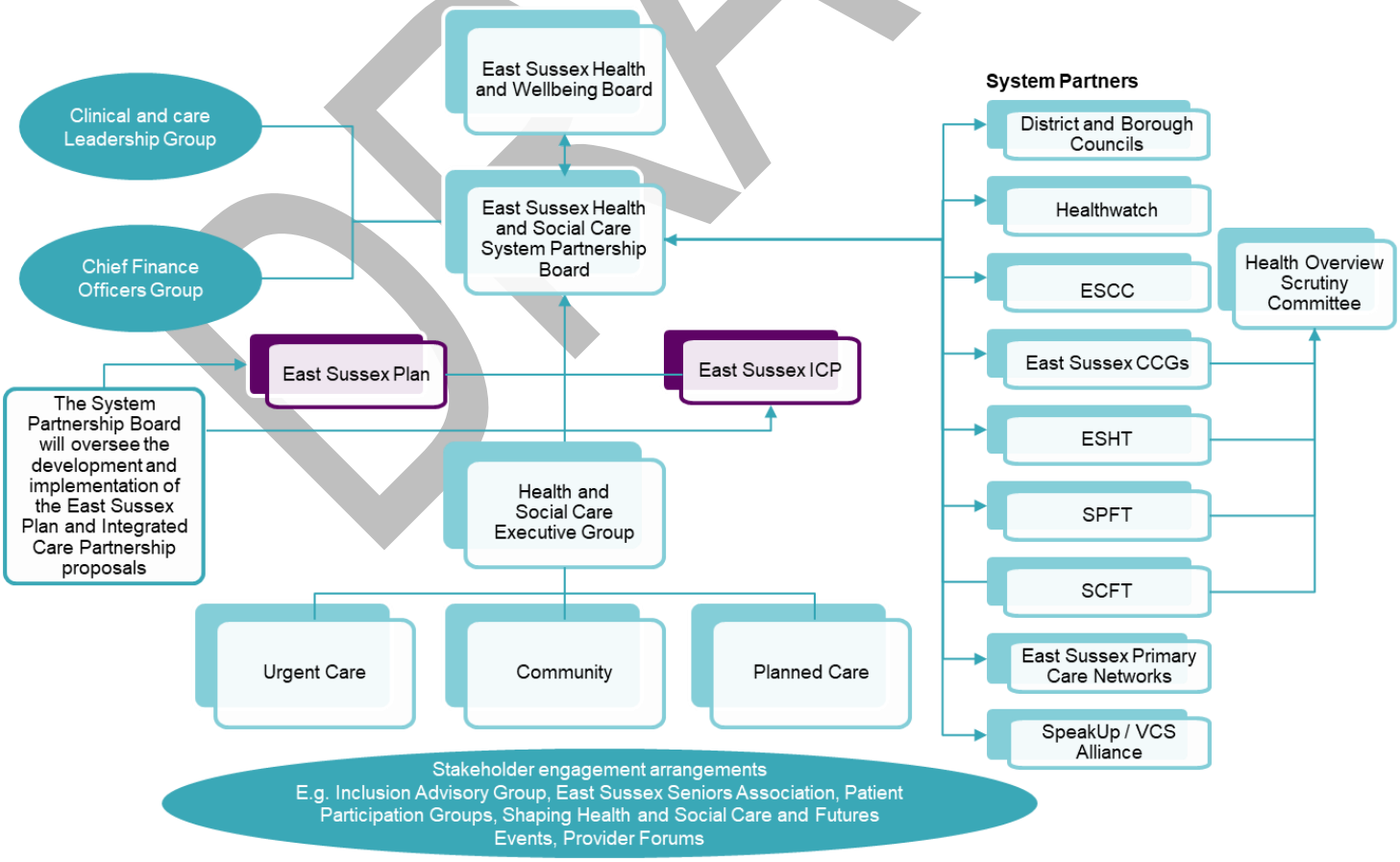
4.1 Our partnership governance

We have launched our East Sussex Health and Social Care System Partnership Board. The System Partnership Board is a strategic planning body, enabling us to work together on behalf of the Health and Wellbeing Board to collectively oversee and lead the delivery of the system transformation required to:

- Meet the health and care needs of our population
- Improve the health of or population and reduce health inequalities
- Respond to the NHS Long Term Plan and local priorities in East Sussex through overseeing the strategic development and delivery of our longer term East Sussex Plan, through aligning organisational plans across our health, social care and wellbeing system.

The new System Partnership Board involves a broad membership from across our system to ensure a clear focus on prevention and the wider determinants of health, as well as making improvements to the quality of care we deliver as a system. This includes Primary Care Networks, NHS Providers, District and Borough Councils, Healthwatch and the voluntary sector, alongside East Sussex CCGs and ESCC as statutory health and social care commissioners. The East Sussex Health and Social Care Executive Group, will also continue to meet to ensure a clear focus on the operational performance of our programme priorities. This will be kept under review as our plans for our ICP and broader system working take shape.

The structure below shows the current key elements of our partnership governance and the lines of accountability. It will evolve over time, for example, as our East Sussex Integrated Care Partnership (ICP) emerges.



DRAFT

Figure 2: Key elements of Partnership governance

4.2. Developing our Integrated Care Partnership

The System Partnership Board's responsibilities will include developing our future East Sussex Integrated Care Partnership (ICP), with initial proposals being shaped for April 2020. The ICP will ultimately govern how we operate together in a more integrated way in our localities across primary, community, mental health and social care with consistent pathways into and out of hospital care when this is needed, and ensuring strong links with services that impact on the broader determinants of health, for the benefit of our population. Over time it will develop to encompass relationships and pathways with services accessed by our population beyond the geography of East Sussex, for example, specialist services within Sussex and beyond, and acute hospital services provided within Sussex and Kent.

Our ICP will provide the framework for all providers of health, care and support working in East Sussex to come together to plan, organise and deliver services at the optimum scale to support quality, consistency - making the best use of our collective resources to deliver the outcomes and priorities for our population identified in the East Sussex Plan. Proposals will be shaped to cover:

- The longer term objectives for the ICP and the overall model we will be working towards
- The elements that need to be in place by April 2020
- The specific actions that we will take to deliver the agreed ICP April 2020 proposals, for example agreeing and implementing the common operating model
- A framework for managing health and social care resources in East Sussex to deliver the best possible outcomes.

4.3. Supporting Primary Care Network development

There are twelve PCNs in East Sussex, established on footprints reflecting local relationships and previous locality working arrangements. All the PCNs are now operational, with identified Clinical Directors in place, and delivery of the Extended Hours DES under way. An opportunity for PCNs to increase the pace of their partnership work will be provided through the local offer of a PCN accelerator programme during September 2019. Four specific areas of focus have been identified, for PCNs to accelerate and respond to the challenges and focus on:

- The development and acceleration of a PCN to progress at pace, mature and deliver their ambition
- Delivery of the Sussex STP Clinical Variation Programme ambitions and requirements (Musculoskeletal falls, Diabetes, and Cardiovascular disease)
- Responses to the requirements of the LTP (including anticipatory care, personalised care and early diagnosis for cancer)
- Integrated joint working of the PCN with other providers to better support integrated care, MDTs and improve the PCN population health; and better integrate urgent or planned care pathways to improve system flow, avoid admission and improve value for money.

Some PCNs are taking up the opportunities offered through the Additional Roles Reimbursement Scheme (ARRS), such as the employment of social prescribers and pharmacists (this will take into account existing extended roles that we have already implented in the county), whereas others continue to explore their options. The CCGs are supporting them in these discussions, including exploring the potential for alignment with the current CCG commissioning of social prescribing.

Public Health are working to compile Population Health packs to help PCNs make informed decisions regarding their priorities for development and strategic direction. PCNs are currently completing a self-assessment against the national NHSE maturity matrix, which will help shape

DRAFT

their response to the recently published prospectus detailing the national support offer.

The Director of Primary Care meets regularly with each PCN to discuss their plans and how CCGs can support them, and the wider CCG Primary and Community Care team members are being repositioned as more externally focussed in order to directly support PCNs. To share good practice and ensure progress is maintained, monthly CCG / PCN / provider meetings have been established, commencing in October, and quarterly Sussex wide meetings will commence in November with support from the National Association of Primary Care.

There is a place for collective representation of the East Sussex PCNs on the new Health and Social Care System Partnership Board, alongside ESHT, SCFT, SPFT, the East Sussex CCGs, ESCC and wider system partners including the VCS. The SPB will oversee development of our East Sussex Plan and ICP proposals, including the full implentation of our target operating model for community services, once this has been agreed. Arrangements are being put in place for full engagement of PCNs in the development and design of the target community operating model, including ensuring closer system working and integration with mental health services at the community and locality level.

Work is also being taken forward on developing of Local Commissioned Services (LCS) in the context of PCNs and potential alignment across Sussex to include cancer LCS, respiratory / COPD LCSs and Enhanced Care in Care Homes LCS, and diabetes prevention, with consideration of provision on PCN-basis. The Diabetes prevention LCS will support referrals to the National Diabetes Prevention Programme. This will build on the schemes currently in place in East Sussex to ensure alignment.

There have been approaches to trialling and delivering multi-disciplinary working in community and primary care developed through our integrated care programmes to date. For example, SCFT implemented a programme of Multi-Agency Team meetings (MATs) that bring together GP practices and community health, social care and voluntary sector services to address the needs of the most complex and vulnerable patients. The role and remit of MATs is now under review with SCFT and CCG clinical leads, with a view to re-aligning their operation to the new PCN model of working, including further consideration in the context of the work to develop a common operating model.

5. Supporting our system to deliver our plans

5.1. Our workforce

5.1.1 Sussex wide developments

Across the Sussex Health and Care Partnership Human Resources (HR) and Organisational Development (OD) leads work together to coordinate HR, workforce and OD activities across Sussex including design of development opportunities. In practical terms, the workforce and OD priorities for Sussex have been agreed to ensure delivery against the NHS Interim People Plan and organised into five workstreams, including Talent Management and Leadership Development. Each workstream has, or is developing, a set of objectives and is led by a either an HR Director or Chief Nurse or both from within our Sussex system.

One of the underlying themes for several of the workstreams is addressing the skills gap identified following a baseline assessment carried out in the spring, with a particularly focus on nursing vacancy levels.

DRAFT

For primary care, Health Education England (HEE) has produced a new governance structure and standards for the evolving role of Training Hubs, previously known as Community Education Provider Networks (CEPNs).

Sussex Health and Care Partnership have embraced this new way of working and created a Sussex Training Hub that will provide strategic direction for locality training hubs, such as the East Sussex Training Hub. Investment is being made by HEE to ensure the Sussex Training Hub and the locality Training Hubs have the necessary infrastructure to meet the standards required within the HEE maturity matrix, thereby enabling the training hubs to support the development of Primary Care Networks and their workforce plans. For example, this will include Workforce Planning and Workforce Information resources at Sussex Training Hub level to provide a consistent approach to workforce planning in primary care.

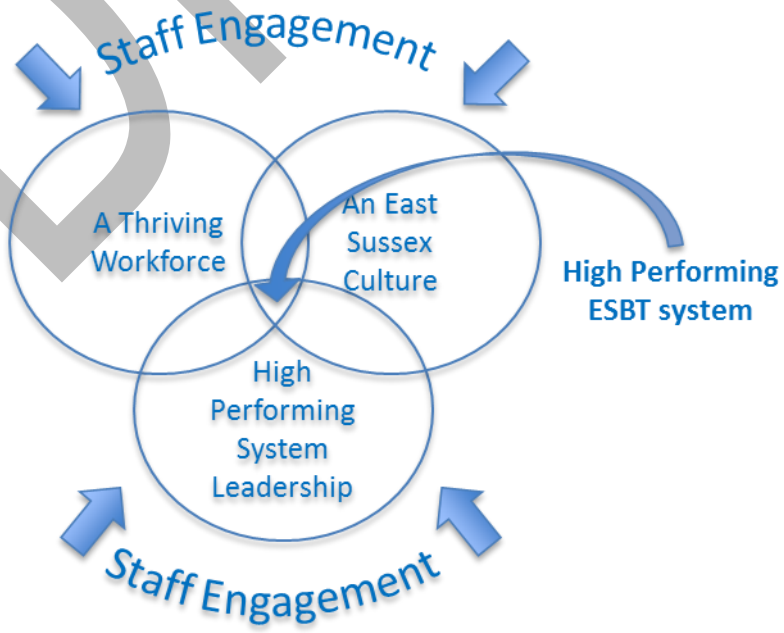
5.1.2. East Sussex draft OD Strategy - our strategic vision

Within East Sussex we have established an **East Sussex Organisational Development Network** and a Strategic Workforce Group, to develop the relevant initiatives to ensure our East Sussex workforce of the future is well placed to deliver improved health and care for local people.

East Sussex OD leads have developed a deeper understanding of each other's organisations, building an East Sussex OD Network (the Greenhouse Group) and co-producing a draft 'place' People (OD) Strategy. Our workforce is critical to our success both at a macro and a micro level; our staff can make a success of system-wide transformation and are central to the experience of those who use our services. We believe that, underpinned by staff engagement, there are three key themes to empower our people to deliver the best integrated health and care for local people. We need to build:

- An East Sussex Culture
- A Thriving Workforce
- High Performing System Leadership.

All three themes are critical to East Sussex becoming a high performing system. The model below outlines the interdependency of these themes in delivering the system workforce that we need for the future of health and care locally.



DRAFT

5.1.3. Delivering this strategy

Our East Sussex OD Network will drive the delivery of this strategy supported by the recently trained cohort of 42 OD Practitioners working closely with organisational communications and staff engagement teams. It will be important that this is driven in the context of our local East Sussex work to create an Integrated Care Partnership that is financially sustainable for the future, and also aligns to the Sussex Health and Care Partnership. As such, our clear governance arrangements and senior support for this ambitious strategy are key to its success and delivery.

5.1.4 Translating the strategy into outcomes for local staff and local people

We anticipate that the key outcomes from the delivery of this strategy, based on local experience, specialist expertise and research will be:

- A clear, understood lived vision
- Shared values and behaviours
- Improved motivation, staff retention, ability to recruit
- A stable, adaptable, creative and innovative workforce
- Happy, healthy and productive staff.

5.1.5. East Sussex Workforce priorities

We have an established Strategic Workforce Group (SWG) made up of senior workforce and HR professionals representing each of the East Sussex partner organisations. The SWG initially developed a two year workforce strategy in 2016 designed to support the delivery of the workforce needed to achieve the integrated care models within three priority workstreams (Integrated Locality Teams, Urgent Care and Primary Care).

Each year the SWG reviews its strategic priorities to ensure the strategy continues to reflect the East Sussex workforce needs in terms of closer working and the introduction of new care models. This will play a critical part in furthering the integration agenda and the NHS LTP and local ambitions to implement our ICP and a Sussex Integrated Care System.

East Sussex Locality Training Hub priorities

The East Sussex Locality Training Hub works with available funding to deliver workforce training priorities. For example, HEE KSS has previously provided operational plan funding which was combined with GPFV investment by EHS and HR CCGs to implement care navigation in GP practices, bursaries for newly qualified GPs and funding a two year GP Fellowship programme.

The East Sussex Locality Training Hub will use funding made available through CCGs, NHSE HEE KSS and the SHACP to support the following identified priorities to help address the workforce issues within primary care:

- GP Retention schemes funded via NHSE and the SHACP
- Creation of Educational Incentive scheme/hubs to increase training within GP practices where this is currently lacking
- Support to Primary Care Networks with developing workforce plans (as per the NHS LTP)
- Continued support to practices introducing care navigation.
- Support Social prescribing implementation and ensuring it complements care navigation
- Creation of GP Fellowships (e.g. Digital Fellowship) to improve retention of newly qualified GPs and broaden experience
- Creation of an East Sussex Academy as part of long term recruitment plans.

DRAFT

Priorities to support local transformation

Overall the East Sussex workforce priorities for 2019/20 to help deliver our East Sussex integration and transformation plans have been agreed as follows:

- Support to delivering the Sussex workforce priorities, ensuring East Sussex representation on each of the five Sussex workforce workstreams
- Identify opportunities for working collaboratively in terms of introducing new, blended, and/or enhanced roles to address the skills gap within East Sussex. This covers the potential workforce development needed to support transformation of integrated community and out of hospital care, urgent care, planned care and primary care, as well as the approach to the comprehensive model of personalised care
- Design and delivery of East Sussex OD plan (as described above).

5.2 Digital requirements

The East Sussex Health and Social Care system is delivering on a long term digital strategy to support the care we give our people in line with the NHS Long Term Plan. Over the next five years we will continue to work closely with our partners across Sussex within the Sussex Health and Care Partnership to deliver on the following themes of the Locally Held Care Record (LHCR), remote care and the wider digital strategy:

- **Our Connected Care** – giving the practitioners who care for me the information they need from all the settings in which I receive care; ensuring that I only have to tell my story once; and that my journey through the health and care system is supported by clear messaging from one setting to another about my needs
- **Transforming Outpatients -** patients 'not having to attend outpatients unless they are required to do so', by deploying remote care alternatives to traditional outpatient appointments.
- **Our Personalised Health** – giving me access to, and control over, my own information. This means I will have greater agency in my care, allowing me to better understand my ability to take an active role in my wellbeing. It will allow me to communicate my needs more effectively and in better time with the right care professionals allowing them to deliver their role more effectively. A citizen portal is also being developed within the cancer space. A Personal Health Record (PHR) uses a shared record approach which enables a citizen through a single online identity, to access their health record. Within Sussex there is an ambition for all citizens to have access to their Personal Health Record and the Patient Knows Best solution has been procured to support citizens with multiple co-morbidities. A personalised approach to care that promotes patient empowerment in their health care is a key priority for the Surrey and Sussex Cancer Alliance.
- **Our Population Insight** – allowing our health and care system to have a better sense of itself; a better sense of what care is being delivered within a complex integrated network of health and care providers working as partners to serve 1.8 million people across Sussex; and through the evidence an integrated longitudinal health record for everyone will allows us to obtain, improve the outcomes we deliver through the services we provide

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

DRAFT

LTP	Priority	Themes	East Sussex initiatives
Empowering people	• Access to manage care • Long term conditions – telehealth and devices • Patients hold their care plan	Our Personalised Health	PHR in Cancer, Diabetes and beyond Online consultations Portals in social care Improve digital inclusion in our population Rationalisation of local service directories across CCG and Social care Integrating with the NHS App ESCC is leading work on TELECARE establishing the integrated community diabetes care service which is underpinned by data between GPs and the community.
Supporting health and care professionals	• More satisfying place to work – more effective tools • Increasing pace to out of hospital based care	Our Direct Care	Integrated Care Record allowing professional a better view of the person they are caring for Supporting teams integrated across health and social care to better work together Smarter Working and Agile Practitioner – how technology can be harnessed to support more flexible and effective working practices GP digital fellow – to work with the system to support the move to a digital first model and grow a clinical digital lead network (reference CPILF)
Supporting clinical care	• Technologies enabling pathway re-design • Co-production between patients, clinicians and carers	Our Direct Care, Our Personalised Health, Our Population Insight	Work with the developing LHCR to provide a new set of standards practitioners and service leaders can depend on to design new pathways, and helping to deliver a workforce that understands how digital can transform the way we deliver care. Integrating use of digital across services, removing barriers to sharing care information between providers, and between our population and the practitioners delivering there

DRAFT

LTP	Priority	Themes	East Sussex initiatives
			care, allowing co-production of pathways and people to manage their care. Out of work with the Information Sharing Gateway to provide the governance to support increased sharing and the ES Integrated Care Record and prototype LHCR Orchestration Layer to provide the technology. Digital work stream to support both outpatient and emergency department transformation
Improving population health	• Population insight to understand greatest health • Provide evidence to improve the way we change	Our Population Insight	East Sussex is an early adopter of the Sussex Integrated Dataset to support the transformation in social care and community health into integrated working by providing the evidence for the benefit of change
Improving clinical efficiency and safety	• Improving ways of working between practitioners, to allow more effective integrated working	Out Direct Care	Integrated Care Record and Information Sharing Gateway

Our key NHS healthcare providers will also be working to deliver increased digital capability, in line with the national and regional programmes to ensure that services are digitally enabled. Our providers will agree a trajectory for improvement over the next five years, with associated investment, to build capabilities in key areas, including cybersecurity.

5.3 Estates requirements

5.3.1. Primary Care premises

The delivery of improved GP premises is one cornerstone of the delivery of our LTP commitments, and specifically the future role of primary care and its transformation in relation to the GP Forward View and the Primary Care Networks. The provision of primary care premises that are appropriate, modern and fit for purpose and flexible enough to support the delivery of our plan is therefore key.

The CCGs are continuing their programme of upgrading practice premises in a very challenging financial climate.

5.3.2. Premises Development

Across our CCG footprints we continue to have a number of primary care estate challenges which are exacerbated by ongoing local population growth. These include the size of the premises in

DRAFT

relation to the registered population and the layout and the condition of the buildings, all of which can seriously impact on care delivery in various ways.

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

- Available square meterage Net Internal Area (NIA) per 1,000 registered patients
- Known planned housing developments in the area
- Practice-specific issues, such as suitability of facilities, expiry of leases/planning permission
- Any CQC-related issues.

As part of our whole systems approach to locality development for health and social care services and our drive to achieve integrated working, consideration for any new development has also been given to:

- Ensuring practices have the ability to provide access to the full range of locally commissioned services (LCSs) for their patients
- Ensuring there are no estates barriers to the co-ordination of Extended Hours across practices
- Sharing front of house and back office facilities, clinical and non-clinical staff, where this is practical to avoid duplication and achieve economies of scale
- Ensuring estates considerations are no barrier to practices' key role in teaching and training
- Devising flexible approaches and using opportunities afforded by new digital initiatives.

These criteria have being used to prioritise outline proposals from practices for estates developments from a commissioning point of view.

The actual order in which proposals are being developed and presented is dependent on a number of factors, including the urgency with which the partnerships pursue the projects, the congruency of views between possible project partners, the ability to formulate an agreed potential outcome, and also the availability of developable sites and the ability to develop the proposal to financially stay within the framework as set out by the GP Premises Cost Directions.

5.3.4. Development Status

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

In EHS and HR CCGs there are currently eleven new build developments underway or in planning and two significant extensions. This will give each of our eight Primary Care Networks at least one new facility or significant expansion capacity for service developments including those provided under the DES and those provided within the Integrated Hub model.

In order to support the delivery of better quality services and more efficient outcomes, there are 13 active primary care premises developments across EHS and HR. The CCGs plans reflect the need to improve primary care estate and the financial implications of this are scheduled within the five year financial recovery plan.

DRAFT

HWLH CCG currently has one new development underway, which will provide not only a new primary care surgery for the three practices in Lewes, but will also enable integration with other health and social care providers and community and voluntary services.

Status	EHS CCG	HR CCG	HWLH CCG
Project commenced	3	1	1
Approved	3	3	1
OBC	1	2	1
Total	7	6	1

5.3.5. Acute and community estate

We are developing an ambitious programme to address particular areas of concern around ESHT and SCFT and the level of investment required to address the estates maintenance backlog, medical equipment and IT challenges. For ESHT, estate will be addressed through a combination of ESHT resources e.g. depreciation and external bids, PDC, loans etc. ESHT has recently received approval for a loan of £13.86m to address the fire compartmentation issues at Eastbourne DGH. Delivering our urgent care programme will require significant investment at the 'front door' of our main emergency departments, alongside the development of Urgent Treatment Centres. This sits alongside significant investment within the hospitals on backlog maintenance and infrastructure, medical equipment and digital capability. Working with and through the SHACP Digital and Estates groups, these plans will continue to be refined and developed over the coming months. Capital schemes to improve clinical outcomes at the "front door" include the development of Single Assessment Unit/UTC at Conquest Hospital (£6.28m) and the development of the UTC at Eastbourne DGH (£3.78m). This is however, wider investment around the front door and does not preclude delivery of the UTC model by December 2019.

Through the development of the SHACP Estates Strategy we are working with colleagues on developing capital bids for the Single Assessment Unit/UTC at Conquest Hospital, UTC at Eastbourne DGH, Cardiac Catheter lab provision, Ophthalmology service modernisation/relocation, Day case unit at EDGH, Non-clinical space rationalisation, Medical Day case unit and Maternity.

SCFT is the main provider of adult community health services in High Weald Lewes and Havens and occupies three community hospitals within the area; Lewes Victoria Hospital, Crowborough Hospital and Uckfield Hospital. NHS Property Services own these buildings and SCFT deliver the services. SCFT has been working with commissioners, GPs and NHS Property Services to develop proposals for an Urgent Teatement Centre at Lewes Victoria Hospital, enabling an enhanced offer for local people in line with our Integrated Urgent Care strategy. There is currently a Minor Injuries Unit at this hospital site and a plan agreed for a brief closure of this service, with interim arrangements to be put in place whilst the redevelopment work takes place in readiness for the UTC to open in Spring 2020. SCFT will work with local GPs using an innovative clinical model to deliver the national standards for UTCs.

The Integrated Primary Urgent Care provision is also being reviewed across High Weald Lewes Havens, and having finalised the plans for the Lewes UTC, the CCG is now exploring options for expanding the offer at Uckfield and Crowborough MIUs with SCFT and other providers, including HERE (who have the contract for Improved Access), IC24, and the recently formed Primary Care Networks.

In the longer term a further review is required to address:

- Distribution of beds to ensure safer staffing, cohorting and to improve system flows (and the use of beds at Newhaven Rehab need to be considered as part of this)
- Address utilisation issues, particularly at Uckfield Community Hospital
- Continued investment to renew diagnostic imaging
- Addressing backlog repairs.

The services and estates mapping will be complex given that the High Weald and Lewes community hospitals face three acute Trusts – ESHT, BSUH, and Maidstone and Tunbridge Wells (Crowborough). A whole system approach will be necessary to determine the required strategic changes to this estate.

SCFT is also working with GPs in Lewes to establish the UTC at Lewes Victoria Hospital and to realise the opportunity of the Northern Quarter development that improves the primary care infrastructure in the town. Where there is no estates project per se, it should be noted that SCFT is committed to improving the integration of community health services in line with PCNs and this will drive future estates planning that will increasingly support primary care and community based health services in a more integrated approach.

ESHT and East Sussex CCGs are working together to redevelop/improve the provision of GP premises for example in Seaford and Newhaven and the establishment of community hubs. Similarly, SCFT is actively engaged with GPs within the Havens PCN to develop the Newhaven Hub, which will enabled the co-location of primary care and community health services (currently based at Newhaven Polyclinic) as well as other public services that have a positive impact on public health, particulary leisure.

Appendices

Appendix 1 Prevention, universal personal care and reducing health inequalities – high level programme description *(to be added)*

Appendix 2 Children and Young People – high level programme description *(to be added)*

Appendix 3 Community – high level programme description *(to be added)*

Appendix 4 Urgent Care – high level programme description *(to be added)*

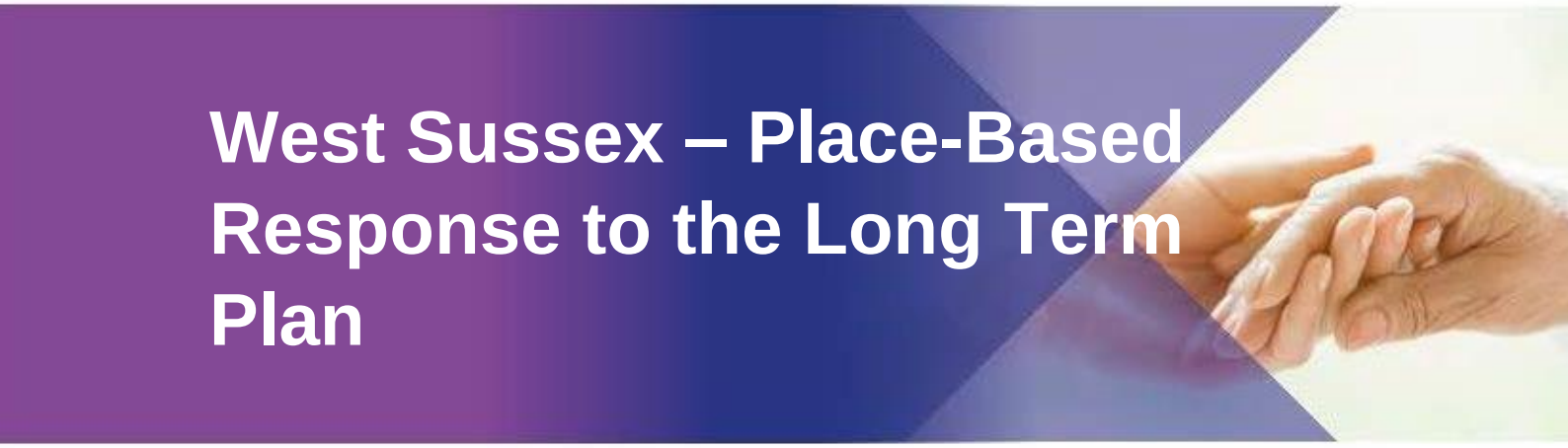
Appendix 5 Planned Care – high level programme description *(to be added)*

Appendix 5 Mental Health – high level programme description *(to be added)*

DRAFT

Sussex
Health and Care Partnership

West Sussex – Place-Based Response to the Long Term Plan



Working together for better health and social care

28th October 2019

V10

Table of Contents

1. Introduction 4
2. The Challenge facing West Sussex – The Case for Change 6
   2.1 Population Need 6
   2.2 Resource, workforce and capacity 7
3. Our Vision for Health and Wellbeing for West Sussex 8
   3.1 Our Health and Wellbeing Strategy for West Sussex 8
   3.2 Planning together for West Sussex 8
   3.3 Partnership working 9
   3.4 Anchor Institutions 11
4. Our Care Model 12
   4.1 Population Health Approach 12
   4.2 Whole Population 13
      4.2.1 Overview 13
      4.2.2 Asset-based approach 14
      4.2.3 Neighbourhoods 15
      4.2.4 Prevention 16
      4.2.5 Social Prescribing 19
      4.2.6 Making Every Contact Count 19
      4.2.7 Connecting Communities 20
      4.2.8 Supporting the development of PCNs 21
   4.3 Urgent Care 22
      4.3.1 Overview 22
      4.3.2 Integrated urgent care 22
      4.3.3 Same Day Emergency Care 23
   4.4 Ongoing Care Needs 23
      4.4.1 Overview 23
      4.4.2 Step Up Step Down 24
      4.4.3 Falls Prevention 26
      4.4.4 A Carer-Friendly NHS 26
      4.4.5 Respiratory 26
      4.4.6 Personalised Care 27
      4.4.7 Elective care 28
   4.5 Highest Needs 30
      4.5.1 Overview 30
      4.5.2 Providing ‘Anticipatory Care’ 31
      4.5.3 End of life care 31

5 Children and Young People 34
6 Enablers 36
6.1 Workforce 36
6.2 Digital and IT 37
6.3 Estates 37
6.4 Communications and engagement 38

1. Introduction

West Sussex is a large and diverse county, covering over 750 square miles and home to over 855,000 people. It remains one of the least deprived areas in the country. In relation to the Index of Deprivation (2015), the county ranks 131st of 152 upper tier authorities (1 being the most deprived and 152 being the least deprived). The county mostly has a relatively high life expectancy, low unemployment, low child poverty rates and an outstanding natural environment and rich cultural assets.

Towns in West Sussex are frequently featured in national surveys and rated as top places people choose to live, retire or work. We rank in the top quartile of Local Authorities (LAs) on a range of measures known to have an impact on longer term health and wellbeing including the rate of employment for 16-65 year olds and first time entrants to the youth justice system. Teenage pregnancy has more than halved over the last 10 years, from 31.3 per 1,000 15-17 year olds in 2005 to 12.2 per 1,000 in 2016 and deaths (under 75 years) from cardiovascular disease (including heart disease and stroke) have fallen dramatically over the last 10 years from 88.6 per 100,000 in 2004- 2006 to 60.7 in 2015-2017. Overall, older people in the county are relatively healthy and the county is a great place to live. More people are continuing in paid employment well past the "traditional" retirement age, and older people provide considerable caring support to their families and friends, and the wider community.

However, this masks the health inequalities within the county. Some areas in Arun rank amongst the 10% poorest neighbourhoods in England. We know that the environment in which people are born, grow, live, work and age has a profound effect on the quality of their health and wellbeing. Many of the strongest predictors of health and wellbeing, such as social, economic and environmental factors, fall outside the healthcare setting. These wider determinants of health have a significant impact on people's health and wellbeing. The poorest and most deprived are more likely to be in poor health, have lower life expectancy and likely to have a long term health condition (LTC) or disability.

In West Sussex, NHS and LA partners have agreed to co-produce a joint response to the NHS Long Term Plan (NHS LTP) within the framework of the Sussex Health and Care Partnership (SHACP). The response is being developed following an extensive period of public and stakeholder engagement and will provide the basis for a delivery plan to achieve the joint Health and Wellbeing Vision for the county, as well as delivering a local response to clinical priorities and the objectives set out in the NHS LTP.

This process provides the NHS with an opportunity to work closely with local government and other partners to build on existing local efforts; and strengthen and implement preventative interventions that will close the local health and wellbeing gap, such as:

- Supporting a good start in life, including delivering a whole systems approach to healthy weight and promoting emotional wellbeing and good mental health in children
- Improving the health and wellbeing of working people through the development of workplace health and wellbeing programmes
- Preventing the development of LTCs through primary prevention programmes focused on the major causes of ill health, including smoking, poor diet, lack of physical activity, alcohol, mental health and loneliness
- Improving health outcomes for people with LTCs, including cancer through a staged approach of early detection, support for self-care and robust clinical management of

LTCs by addressing the physical health of those with mental illness to reduce the life expectancy gap

- Empowering citizens to remain independent in their own homes, taking an asset-based approach to support carers, strengthen social networks, communities and places - with the aim of making the healthier choice the easier choice and default choice
- Providing prevention advice and support to other clinical networks in Sussex footprint, such as the Cancer Alliance, Local Maternity System (LMS) and other clinical work streams and programmes of work, for example, screening and immunisations

Integrated working across health and care provides the opportunity to deliver the best possible outcomes for local people and achieve the best use of collective public funding in West Sussex. There is a strong national and international evidence base that demonstrates the value of integrated working in improving experience and outcomes, alongside delivering better value for money.

By developing a joint West Sussex health and care plan and having a clear place-based focus in our NHS LTP submission, we will ensure that the priorities for service transformation and integration required to deliver a new service model for the 21st century are grounded in the needs of our local population.

2. The Challenge facing West Sussex – The Case for Change

2.1 Population Need

Longer life expectancy has been a considerable public health success story. People are living longer but spend around 20% of their lives in poor health, often with multiple complex conditions. This presents challenges and pressures.

The population has increased by 9% over the last 10 years. This is in line with increases seen at a national and regional level, with the largest increase, of over 22%, in the 65+ age group. The population is, therefore, growing, and growing older. The county has a population of 192,500 over the age of 65. This is 22% of our population and compares with 19% in the South East and 18% in England. This pace of change is set to increase. For the past 15 years we have had, on average, 2,500 more people aged 65 years old each year. The population in West Sussex is projected to increase by a further 8%+ from 2016 to 2026 with larger increases projected in the older age groups (20%+) in the same 10-year period.

As the population ages, more people will be living longer with a LTC or disability and many people will be living with multiple LTCs. Almost two thirds of those aged 65-84 in West Sussex are estimated to live with two or more LTCs. This rises to four in five of those aged 85+. Many LTCs are strongly associated with age, but lifestyle risk factors are also important. A significant proportion of these LTCs are preventable. Loneliness and social isolation are also very real problems for our ageing population. More than 72,500 people above the age of 65 are living alone. A survey in 2013 found that 1 in 4 of older people reported being moderately or severely lonely.

Overall life expectancy is high compared with England, 80.6 years for men in (2015-2017), and 84.1 years for women, both 1 year higher than across England. Whilst life expectancy has increased, considerable inequalities persist. There are, for example, considerable differences in life expectancy between the most deprived residents and least deprived, 7.6 years difference for men, and 6.0 years difference for women (2015-2017). Life expectancy for those with a mental health problem or a learning disability is also significantly worse.

Alongside this trend, there is a gradual deterioration in outcomes for local people, a widening of health and wellbeing gaps and the potential impact of austerity on the local economic climate. Healthy life expectancy, for example, appears to be plateauing for men and has been falling for women. Female healthy life expectancy was lower than male healthy life expectancy in 2015-2017 (63.6 years compared with 65.8 years), suggesting a failure for our existing models of care in terms of responding to the changing demographic.

People have very different expectations than they had in the past. They want more choice and are often experts in their own care. People expect clear information about what treatment involves, the evidence that it works, the outcomes it will achieve and what happens next. They are less concerned about organisations, systems and pathways and they expect to be able to access information and communicate with the NHS using digital technology. Feedback from the public is that services are not joined up and that a lack of coordination across the system contributes to a poor experience of care.

2.2 Resource, workforce and capacity

The gap between available resources and projected spending requirements is expected to rise unless we act, and evidence suggests that adoption of new ways of working is not fast enough or effective enough to moderate the impact of demand growth. Analysis undertaken highlights evidence that there could be more management at the front end of pathways; that there is considerable and unwarranted variation between GP practices in terms of the use of secondary services; that we have fallen behind in areas such as keeping vulnerable people in stable employment and accommodation; and, importantly, that we have not invested in securing the benefits available from prevention.

Staff shortages in many parts of West Sussex combined with high turnover are also placing services under severe pressure. We face serious recruitment challenges. Nurses, GPs, occupational therapists, social workers and care support staff are all difficult to recruit. High turnover, particularly in the first year of employment, is costly and disruptive to services. Reducing reliance on a temporary workforce is a key driver for all providers. The challenge for employers is to create an environment and a culture that makes people feel valued.

There is also a capacity gap in general practice which is not resolvable by recruitment alone, and a new approach is needed. Projected demand for primary care is greater than practices' capacity to deliver, and faced with a recruitment crisis, there is a growing risk of service failure in general practice that could severely impact on all health and care services.

3. Our Vision for Health and Wellbeing for West Sussex

3.1 Our Health and Wellbeing Strategy for West Sussex

Our Vision

"West Sussex is a great place in which to grow up, achieve, raise a family and grow old, in strong, safe and sustainable communities – it is a place where improved health and wellbeing is experienced by all our residents, and the health and wellbeing gap between communities is reducing."

In 2019, NHS and LA partners from across West Sussex set out a strategy for the health and wellbeing of people in the county. *"Start Well, Live Well, Age Well: West Sussex Joint Health and Wellbeing Strategy 2019 – 2024"* is a tool to enable partners to set out a plan for action which will inform the planning, commissioning and provision of care and support. It aims to be concise and purposeful rather than a comprehensive review of work across the health and social care system. The Strategy provides a framework for the planning, commissioning and provision of services by NHS Trusts, Clinical Commissioning Groups (CCGs), LAs and voluntary sector organisations in West Sussex. It is not a stand-alone document, but sets the direction of travel, bringing together the many strategies and plans we already have under one clear vision and purpose.

The purpose of the strategy is to:

- Provide a context, vision and overall focus for improving the health and wellbeing of local people and reduce health inequalities at every stage of people's lives.
- Identify shared priorities and outcomes for improving health and wellbeing and reducing inequalities based on our Joint Strategic Needs Assessment (JSNA).
- Support effective partnership working that delivers health improvements for all.
- Set out a way to support and drive the innovation required to enable change.
- Support partners to embed these priorities within their own organisations and reflect these in their commissioning and delivery plans.

3.2 Planning together for West Sussex

Strong relationships between local government, the NHS, and communities are critical to the implementation of our strategy and a population health approach which puts the individual at the centre of the design and delivery of care and support. In Sussex we will have 3 "places" where NHS and LA planning are aligned. These will be co-terminus with upper tier LA boundaries for Brighton and Hove, East Sussex and West Sussex. Each place will be supported by 1 or more Integrated Care Partnerships (ICPs) responsible for delivering improved outcomes for our population.

We will use our response to the NHS LTP as a catalyst for developing West Sussex as a "place". We will focus on an approach which prioritises prevention, delivers person centred care, and tackles health inequalities. To ensure implementation, a delivery plan will be developed. The plan will be an integrated health and social care plan, focussing on the people who live, work and visit the county; across physical and mental health, and health and social care services for children and adults; from improving health and prevention through to primary and secondary care. The emphasis will be on setting out the

transformation priorities we need to deliver jointly to meet the future health and care needs of our population.

The process for developing the plan will be led by the Chief Operating Officer for Sussex CCGs, the Executive Director, Children, Adults, Families, Health and Education for West Sussex County Council (WSCC) and Chief Operating Officers from our provider organisations. They will engage with key partners to establish the right governance framework to deliver an initial plan by April 2020 and a detailed joint delivery plan covering how we will address our priority areas by September 2020. The initial plan will aim to:

- Refresh our place-based strategic plans to reflect the widest opportunities for joint working across the wider determinants of health
- Set out an initial view of the service improvements which we are realistically aiming to achieve over the next 4 years
- Establish key principles for system architecture in West Sussex including the development and delivery of ICPs; integrated commissioning; and designing a population health approach
- Describe a framework for programme governance
- Set out the finance, activity, digital, workforce and estates implications of our plans
- Describe how we will work with our communities and our staff to ensure better outcomes.

3.3 Partnership working

There is a shared recognition that our governance requires refreshing with a commitment required to a clear scheme of delegation and active participation in developing local partnerships. Figure 1 sets out our framework for partnership working. An interim partnership executive group, formed from provider and commissioner organisations, will be established to develop the infrastructure required to support governance, assurance, performance and financial management across the partnership map. The group will also prioritise activities to support improved partnership working over the period to April 2020 as follows:

- A joint plan for the development of an outcomes approach with clarity about;
    - how the measures will be developed
    - how services will change for people, communities and populations to reflect an outcomes approach
    - how outcomes will become a routine part of individual care planning, supporting people to assess themselves and to take more control of their care
- A programme of work using disaggregated data from current JSNA to identify inequalities in outcomes between different social groups and to support the prioritisation of interventions within specific communities across West Sussex
- Agreed plans to deliver an integrated care record and the development of a common data set and methodology to stratify risk covering health, social care and housing needs
- A shared approach, at place, towards the development of ICPs
- A framework for impact analysis which sets out the quantified impacts expected across the system including those on “downstream” hospital utilisation and the outcomes for populations.



Figure 1: Our framework for partnership working in West Sussex

A fundamental enabler to deliver our vision is the development of ICPs where NHS and LA providers work together to deliver outcomes and ambitions for the population. An ICP will work collaboratively with commissioners and communities to co-design new models of care and set the strategic direction and outcomes for the population. It is a partnership of health and care providers, including LAs, acute hospital trusts, community providers, primary care networks (PCNs), and mental health providers. In West Sussex, ICPs will also include organisations and bodies which span populations, such as district and borough councils, the voluntary sector, schools, the police, and other providers of health and care.

ICPs will be an alliance of "sovereign" providers, designed to integrate care around our local population, improve health and care outcomes and address health inequalities. Accountability for setting up ICPs will reside with our local providers. They will work closely with CCGs and LAs to provide a framework which supports partners to ensure delivery of improved outcomes in line with our joint delivery plan for West Sussex.

Across Sussex, we will work as a system to deliver high quality specialist and complex services to improve outcomes and reduce inequality. This will require us to work "at scale" to plan, to share best practice and deliver the best care. Individual hospitals will work together to provide the best quality, safety, value and equity of care in a timely manner; specialist centres will be developed for more complex services (such as stroke); and we will manage some of our essential supporting services, such as digital, workforce and estates, at a Sussex level, to deliver the infrastructure required to support continuous quality improvement.

One of the areas where we will work at scale across Sussex and at place is mental health. Colleagues across West Sussex have made some significant contributions to the SHACP Mental Health Programme. Mental health features strongly in the NHS LTP with the creation of new ring-fenced funding of £2.3 billion a year nationally. West Sussex has developed its own Mental Health Programme Board to oversee the transformation of key work streams such as Patient Flow, ensuring strong connections across a broad sector.

We are actively engaged in the prioritisation of the MHIS for Sussex and will be working closely with our partners in health and social care to ensure that West Sussex strengthens the provision of services which require a local approach. For example, we will invest in transforming community services with a focus on supporting people to get the support they need, when they need it close to home. Suicide Prevention is already making traction across West Sussex with specific activities focussed on our local population crossing the traditional boundaries of health and social care.

At place, we will be supporting people in our communities presenting at A&E with mental health needs to receive the best possible support through developing Core 24 Psychiatric Liaison Service in our acute hospitals, following a successful bid for £1.2 million of additional investment awarded to West Sussex. We will also be working with our colleagues across Sussex to ensure that our place-based approach to Improving Access to Psychological Therapies is enhanced through local connections to supporting people with LTCs.

3.4 Anchor Institutions

Much of what we will do over the next 5 years is in recognition of position of NHS and LA organisations in West Sussex as “anchor institutions”. Anchor institutions are large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area – they are effectively ‘anchored’ in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land.

Anchors have a mission to advance the welfare of the populations they serve. They tend to receive (or are significant stewards of) public resources, and often have a responsibility to meet certain standards on impact or value. These characteristics mean that our public sector organisations in West Sussex are well placed to have a powerful voice in where and how resources are spent locally. Public sector organisations can make a difference to local people by:

- Purchasing more locally and for social benefit
- Using buildings and communities to support communities
- Spreading good ideas and being models for civic responsibility
- Reducing environmental impact
- Widening access to quality work

4. Our Care Model

4.1 Population Health Approach

We will take a population health approach to improving the health, care and outcomes of people within the framework set out in the NHS LTP. We know a lot about our populations and an important part of our approach is to continue to develop and deepen this understanding through our work with local communities and through ongoing system analysis.

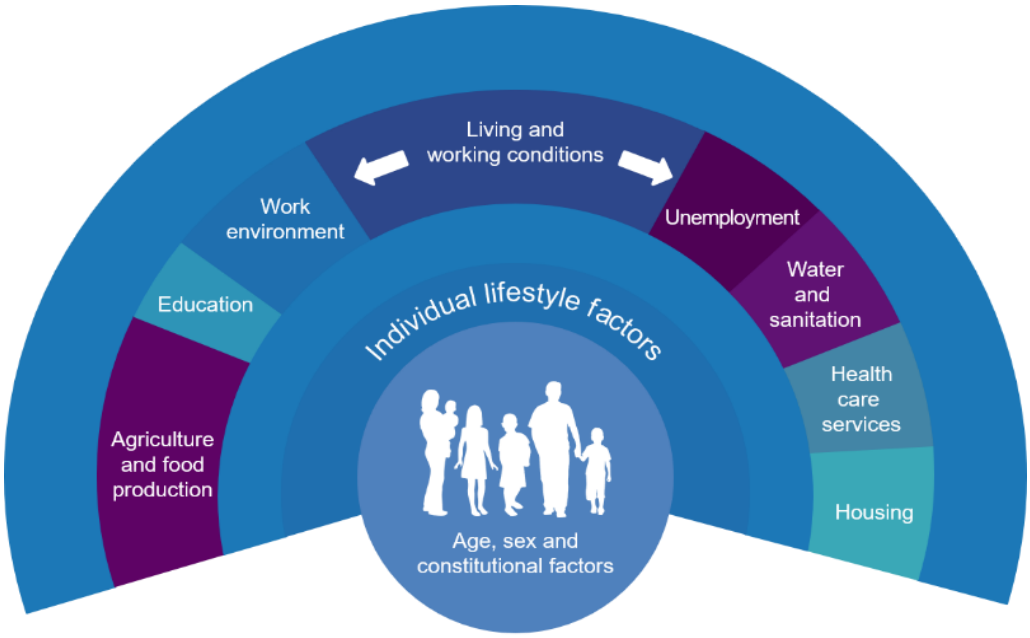


Figure 2: A population health approach for West Sussex

Population health is aimed at improving the health of the entire population, by improving physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities. It includes actions to reduce the occurrence of ill-health, addressing the wider determinants of health, and broader work with partner agencies and local communities.

Whilst our strategic framework for a population health approach is well-developed, our plans for delivery of the care model set out at Figure 3 are not yet adequate. The complexity of the change journey and the degree of transformation across our system will require the development of an infrastructure capable of supporting all partners across West Sussex to work towards improving outcomes. A plan to deliver the key components of a population health approach will be established by September 2020 as part of the joint delivery plan and this process will be led by the Director of Public Health. This process will develop our priority areas for implementation; an engagement framework setting out how we will work with our communities; and an impact analysis.

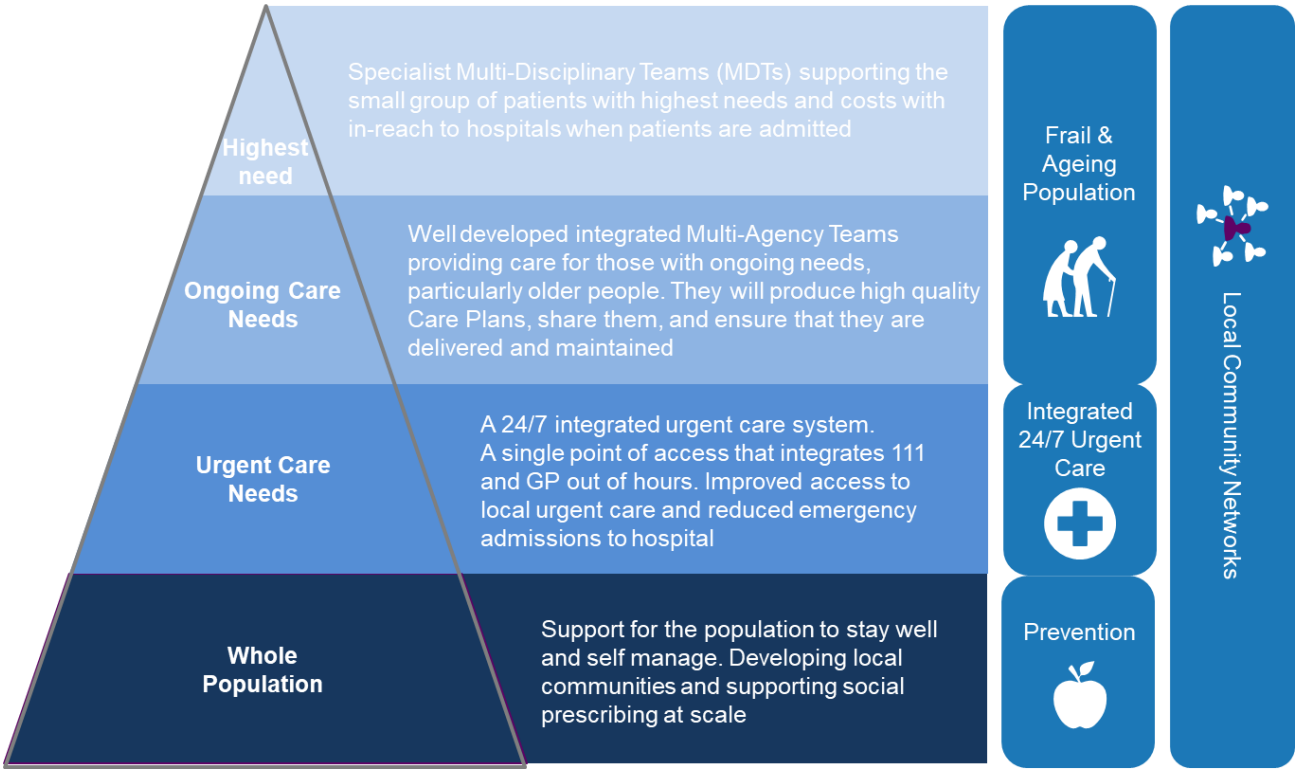


Figure 3: West Sussex Care Model

4.2 Whole Population

4.2.1 Overview

The NHS LTP sets out a clear commitment to increase action on prevention and health inequalities in the NHS. Delivery of these actions will complement existing population health approaches which are already being delivered across the health and care system by LAs, the NHS, Public Health England (PHE), NHS England (NHSE), and community organisations throughout Sussex.

We recognise that widespread cultural changes are needed in our public services to realise the full potential of such an approach, and this involves challenging existing ways of working. We know that if we are to be successful in delivering this approach then we will require bold leadership and a long-term strategic commitment to working differently with local people and communities. To build a new relationship with the public, there needs to be a shared way of working across all of the services operating in a place. A key part of this process will be harnessing LA leadership for key areas of our programme, such as prevention, and closer working between LAs, the NHS, voluntary sector organisations and others to establish a common approach.

Evidence from other areas suggests that it is possible to achieve substantial savings while protecting or improving outcomes, but only if services are genuinely transformed and upfront investment is available to help bring about new ways of working. A population health approach will not be a panacea, but it will provide the framework for a shift to a new model of public service delivery in which patients, service users and communities are involved as active partners in improving health and care.

To achieve our vision, and reduce health inequalities, our approach builds on existing work and sets the direction of travel for health and wellbeing across the county. Divided into three major themes: Starting Well; Living and Working Well; and Ageing Well, the Strategy takes a “lifecourse” approach to improving health and wellbeing as set out in Figure 4 below.



Figure 4: The "Lifecourse" Approach

4.2.2 Asset-based approach

We will be taking an asset-based approach to community development. An 'Asset-based' approach means that public services seek to build on the strengths and assets of individuals and communities to improve outcomes. Fundamental to asset-based working is a change to the nature of the relationship between staff delivering services and those in receipt of services. This shift is about working alongside people based on what will work for them, taking into account their individual circumstances and not assuming that public services

have all the answers. It is about 'working with' rather than 'doing to', and a focus on what service users 'can do' rather than what they 'can't do'.

The types of assets that can be harnessed to improve health outcomes include the following:

- **social assets**, based on relationships and connections with friends, family and neighbours
- **community assets**, including voluntary sector organisations working to improve health and wellbeing, and less formal groups such as book clubs
- **physical assets**, including parks and open spaces, libraries and leisure centres
- **personal assets**, including knowledge, skills, interests, talents and aspirations of individuals

The environment we live and work in can have positive and negative impacts on wellbeing e.g. access to good green spaces, high densities of alcohol and fast food outlets, the emphasis on driving and screen time at work and home. Our environment in West Sussex, natural and built, is a great asset; with historic coastal resorts, seaside attractions, beautiful countryside and lively market towns and villages. The natural environment has a big impact on our physical and mental wellbeing, so maximising health benefits of our environment is important.

In addition to the natural environment, there are over 325 schools; 80 GP practices; 160 community pharmacies; hospitals with A&E departments at Chichester and Worthing and additional NHS hospital sites across the county; 36 libraries; numerous museums, galleries, theatres and historic properties. The county has a large number, and variety, of organisations, groups and associations, fundamental in the delivery of services that support health and wellbeing; supporting individuals, families and communities, enhancing the vibrancy and quality of life in the county.

4.2.3 Neighbourhoods

Our approach will focus upon establishing our "neighbourhoods" as the fundamental unit of care co-ordination. Each will have an attributed population of 30,000-50,000 and will be supported by PCNs, where primary and community teams work with communities and individuals to promote and look after their health and wellbeing. Neighbourhoods will be the focus for prevention, choice, and self-care, and supporting people to make choices about their care and look after their own health priorities. They will focus upon addressing primary behavioural (smoking, drinking too much alcohol, unsafe sex), metabolic (high BMI, high cholesterol), and environmental (air pollution) risks.

Each neighbourhood will be supported by a PCN. The PCN will establish a wider primary care team made up of local GPs, nurses, social workers, pharmacists and the voluntary sector. They will meet often and seek input from a range of other specialist health, social care, community and public services as and when required. Each neighbourhood will have a set of priorities based on the health and social needs of their particular area and may work with other neighbourhoods in West Sussex where the opportunity to work at scale benefits the delivery of outcomes.

Our joint delivery plan will include specific goals for particular groups – for example, greater continuity of midwife care for black, Asian and minority ethnic women and women from deprived groups; an increase in physical health checks for people with severe mental health problems; and investment in meeting the needs of rough sleepers and ensuring better access to specialist mental health support.

Our commitment to our population within the framework of this neighbourhood approach is set out below in Figure 5.



Figure 5: Our commitment to neighbourhoods

4.2.4 Prevention

The recent government policy document 'Prevention is better than cure' (2018) sets out a call to action for prevention to be at the heart of everything we do.

"*Prevention cannot be solved purely by the health and social care system alone. Everyone has a part to play, and we must work together across society. This includes recognising the responsibilities of individuals and families in reducing the chances of becoming unwell in the first place, but also how the wider environment we live in determines our health*".

This is reiterated by the NHS LTP's positive shift towards prevention and reducing health inequalities and in the social care green paper, "Advancing our health: prevention in the 2020s – consultation document", published in July 2019.

Local government public health teams have been working in collaboration with NHS partners to embed prevention into the work of the SHACP. The Population Health Check set out an overview of the population health challenges and opportunities across Sussex, and identified key priority areas. It identified that 75% of deaths and disabilities across Sussex are caused by five conditions – cancer, circulation and respiratory disease, diabetes, bone and joint conditions, and mental health conditions – and these cause the biggest impact on our residents' quality of life and local services.

The Population Health Check also highlighted that "*prevention requires prioritisation and investment across the system*" and recommended the establishment of a vehicle to drive forward whole system engagement in the prevention and wellbeing agenda. A key outcome of the PHC is the establishment of a SHACP Prevention Board that will provide structure and governance for greater collaboration and action on prevention priorities across Sussex.

The purpose of a Prevention Board will be to improve healthy life expectancy and reduce dependency on health and care services through a radical upgrade in prevention, early intervention and self care. The board will provide structure and support to enable system wide change through:

- Maximising impact on outcomes by ensuring a well-co-ordinated and robust approach to prevention across Sussex, where it makes sense to do so.
- Driving forward a population health approach and a common understanding of health and wellbeing needs and evidence based interventions across Sussex.

- Supporting appropriate prioritisation of prevention across the activities of the SHACP.
- Joining up input of PHE, NHSE and Local Government Public Health to SHACP prevention to harness our efforts for maximum effectiveness.
- Providing a focus on wider determinants of health and link into primary, secondary and tertiary health prevention.
- Providing a vehicle for matrix working prevention across the STP governance structure.

The board will not seek to manage the entirety of prevention activity that is already underway, but focus on the added value from working together across Sussex where there are opportunities to do so at scale. This may include, for example, taking a common approach to smoking, alcohol, physical activity and diet across our NHS trusts.

Our Health and Wellbeing Strategy for West Sussex sets out the local priorities and how, working with local partners and residents, it is proposed that these are tackled. Partners in West Sussex will develop a "place-based" plan for prevention in West Sussex for September 2020 as part of the joint delivery plan. The plan will show how we will coordinate prevention activities across the county and within public sector organisations to deliver our local Health and Wellbeing Strategy. A prevention ethos will be championed locally, to change the culture towards prevention, promote personal responsibility for health and wellbeing, and to challenge inequalities. We recognise that it is important to clearly articulate what we understand by the term prevention, as we are aware that it is a frequently used word but can mean slightly different things to different people.

Ideally, we would want to prevent, remove or reduce any risk to health (primary prevention). Where that is not possible efforts should be made to enable early identification and treatment with the aim to cure, slow progression or reduce impact (secondary prevention). Once a problem or condition has arisen the task is to address complications (tertiary prevention) but at this point the condition may be persistent and treatment more costly. These stages of intervention are described in Figure 6.

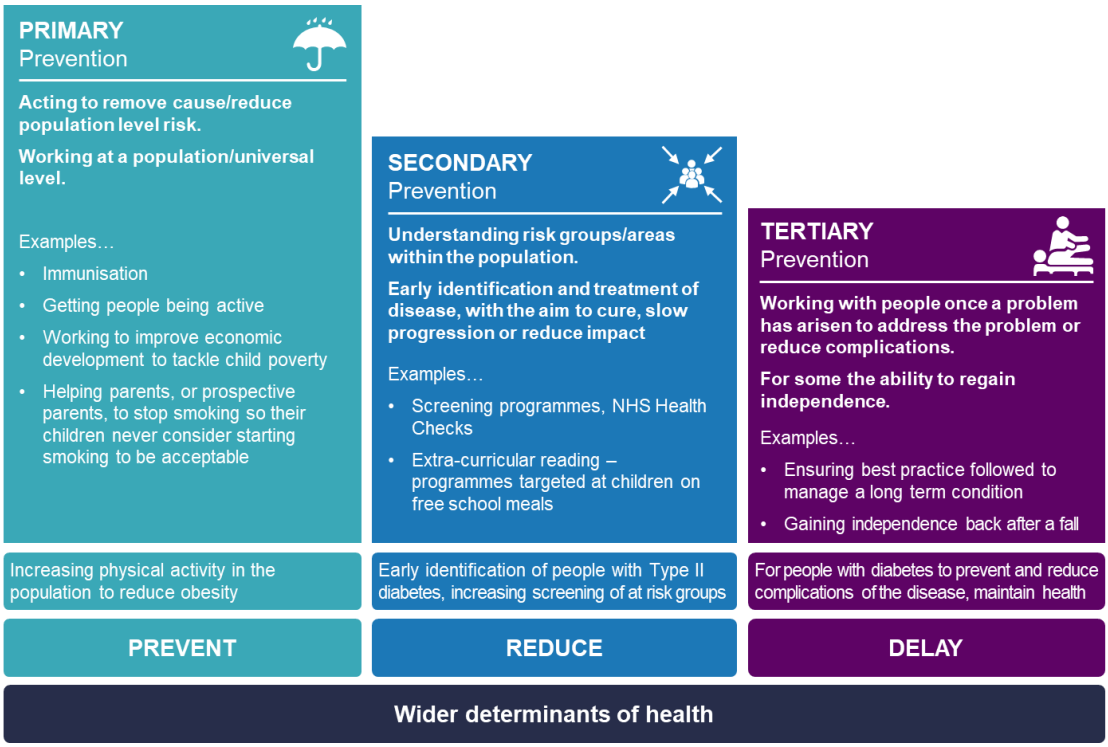


Figure 6: Prevention framework

The NHS LTP identifies five areas (smoking, obesity, alcohol use, air pollution and anti-microbial resistance) where funding will be made available to support prevention through the implementation of specific activities. We will ensure that these clearly link with, complement and boost existing activities, local priorities and objectives; and use existing oversight structures, groups and partnerships. We will work together with partners to ensure that objectives and activities are appropriate, supported and promoted at neighbourhood, place (West Sussex) and ICS (Sussex) levels.

A key local partnership promoting prevention at scale, across the county, is the West Sussex Wellbeing programme. This is a partnership between WSCC and the 7 local district and borough councils offering support and advice to all adults who live and work in West Sussex. This comprehensive programme is offered within each local council addressing health inequalities through targeted prevention programmes addressing local need, and is designed to reach those who are the least engaged to access support.

West Sussex Wellbeing provides a reach into the more deprived communities and incorporates work on key behaviours of smoking, alcohol, diet, physical activity and health and wellbeing checks. It works with local businesses to reach working age adults and supports and promotes leadership at a local level. It also ensures that assets in the local community are maximized, including leisure provision, cultural activities and the work of the local community and voluntary sector. It will provide the framework for our response to the five areas highlighted in the NHS LTP as follows:

Smoking – the Smokefree West Sussex Partnership has set out a detailed "Tobacco Control Strategy (2019-2022)" which contributes to meeting the national objectives through the co-ordinated effort of a wide range of partners. The strategy builds on national plans which establish tobacco control as a comprehensive and coordinated effort to reduce demand, prevent uptake, and support cessation rather than a focus solely on the delivery of smoking cessation services. Using the Department of Health's 10 High Impact Changes to achieve tobacco control, the strategy outlines a collaborative, solution-focused approach across the partnership and commits to a detailed set of actions, identifying interventions that impact across the wider determinants of health for the next 3 years.

Obesity - healthy weight is highlighted in the JSNA and in our Health and Wellbeing Strategy and links closely with the first priority of Start Well which concerns emotional health and wellbeing of our children. However, West Sussex has yet to commit to taking a coordinated, systematic approach to tackling this complex, multifactorial issue. In October 2019, a paper will be provided to the Health and Wellbeing Board which recommends that they endorse a new strategic approach, beginning with the establishment of a Healthy Weight Steering Group which is intended to report into the Health and Wellbeing Board. The group will consider the available evidence and work collectively to develop sustainable, universal approaches to prevent obesity in all children, ensuring there are pathways in place to support those who are obese or overweight.

Alcohol use - the West Sussex Alcohol Network includes partners from health, local government, and the voluntary and community sector. It explores opportunities to make the alcohol care pathway more effective and aims to plan joint responses to national campaigns. The focus for the Network will be to introduce early identification and intervention with primary care, to ensure that people are identified and supported at an earlier stage. Working with other local authorities in the ICS, we are pursuing the introduction of Alcohol Care Teams and, using DrinkCoach, we will ensure that there is online Alcohol Identification and Brief Advice, and via a Skype service extended brief Interventions for increasing or higher risk drinkers.

Air pollution - the Sussex Air Quality Partnership was established to support local authorities with their duties under Environment Act 1995 and implementation of the United Kingdom Air Quality Strategy. The Partnership has formed a West Sussex Inter Authority Air Quality Group (IAAQ) the IAAQ has an action plan which includes developing a public information campaign, working with developers through planning processes to include electric vehicle charging points, and looking at feasibility of differential parking charges and additional air quality monitoring on pay and display machines. In the context of the NHS LTP and recognition of the NHS as an "anchor" institution, the IAAQ is also engaging with NHS organisations to expedite actions on adopting sustainable practices, including use of energy, water and plastic; waste production and waste management; and travel, which requires fossil fuels and contributes to air pollution. The West Sussex Air Quality Needs Assessment (2018) was completed to inform the local air quality strategy (Breathing Better) and this strategy sets out the local priorities and actions for the county.

Anti-microbial resistance - the West Sussex Health Protection Group, a multi-organisational group including CCGs, PHE and LAs is aiming to establish an antimicrobial strategy as part of its scope of work in 2019/20. CCGs in the north and south of West Sussex have infection review action groups that focus on the reduction of Health Care Acquired Infections (HCAIs). We will continue to work collaboratively to reduce all avoidable infections, vaccine preventable disease and antimicrobial resistance.

4.2.5 Social Prescribing

A further example of our effective joint working towards a prevention ethos is the launch of social prescribing, under a co-ordinated 'Going Local' model. It is focused on people aged 18+ with underlying complex social, emotional or practical support needs. We also introduced two targeted social prescribing initiatives:

- Getting back to independence and reducing reliance on health care
- Confident connections – increasing confidence leading to better self-care

In 2019/20 we will seek to develop a coherent social prescribing approach that is aligned for the whole of West Sussex, with shared outcomes, while allowing for local flexibility to respond to specific population needs. Our ambition for 2020/21 is to ensure there is a link worker in place supporting each neighbourhood.

4.2.6 Making Every Contact Count

Making Every Contact Count (MECC) is "A Health in All Policies" (HiAP) transformational approach, based on the foundation that every day there are millions of interactions between public service workers and the public. It is an approach that enables individuals and organisations to develop a different way of working with people to promote and support health and wellbeing. Telling people what to do generally does not work. MECC is about being more attuned to how we interact with people and learning how to spot opportunities to talk to people about their health and wellbeing. MECC enables workforces to:

- Utilise a holistic, person-centred approach to service delivery
- Deliver 'very brief' or 'brief' evidence-based interventions for lifestyle behaviour change, as outlined in the NICE Guidance on Individual Behaviour Change focusing on the key elements of stopping smoking, drinking alcohol sensibly, increasing physical activity, maintaining a healthy weight and diet and promoting emotional health and wellbeing (Five Ways to Wellbeing)

- Know about local support services and how to signpost people to them where appropriate

MECC related skills are transferable and can be used within a workplace health context. The pressures faced by LA, NHS and voluntary sector workforces are well known, and MECC offers a pragmatic solution to scaling up a transformational shift toward prevention as part of organisational culture change. MECC can equip workforces at all levels to be more confident in discussing lifestyle related issues with each other as well as the people they work with.

4.2.7 Connecting Communities

Tackling loneliness and social isolation is an agreed Health and Wellbeing Board and national priority. There are many services and organisations carrying out work that impacts on this area and the evidence base around promising approaches is characterised by putting frameworks and processes in place to support connectivity rather than recommending specific activities / services.

A task and finish group has been convened to scope this area. It has received feedback on proposed approaches from the Public Health Board and from the Health and Social Care Board Business Planning Group and a detailed action plan supporting development is in place. As with other public health approaches to specific topic areas, action is being proposed at population, community and individual levels as set out below.

Tackling Loneliness and Social Isolation (L&SI)		Intervention	Description	Outcomes
Population	Ageing Well communications campaign 'Connect, Get Checked, Get Active'	WS Connection Confederation & Kitemark	Using Dementia Alliance approach – major WS organisations sign up for best practice Connection Kitemark e.g. running volunteer schemes, creating social spaces	Number of West Sussex organisations with Connection Kitemark
		Connection Conversations	Delivery of joint D&B and WSCC listening events across the county to identify local issues, what works and reduce stigma	Identification of issues and what works locally Reduction in stigma
Community		Targeted interventions for key at risk groups	Work with local groups to address needs of at–risk groups (e.g. bereaved with LTCs) including those identified in Connection Conversations	Reduced levels of loneliness and social isolation in at-risk groups
		Local resources	Production of a resource for members, & councillors outlining key actions to reduce loneliness at local level	% of councillors evidencing actions to reduce LSI

Individual		Production and dissemination of E-learning module	Improved knowledge and skills (for both professionals and residents) using a MECC approach to reach, understand and support people affected by L&SI	% of people taking module evidencing use of reach / understand / support approach

4.2.8 Supporting the development of PCNs

Improving care outside hospitals is one of the headline commitments in the NHS LTP. Alongside PCNs, the plan commits to developing 'fully integrated community-based health care'. This will involve developing multidisciplinary teams (MDTs) working across primary care and hospital sites. Over the next 5 years, all parts of the country will also be required to increase capacity in these teams so that crisis response services can meet response times set out in guidelines by the National Institute for Health and Care Excellence (NICE).

The 80 GP practices across West Sussex have organised themselves around 19 PCNs. Our PCNs will enable greater provision of preventative, proactive, personalised and coordinated health and social care. They will provide the leadership, resource and capability for wider primary care teams to support communities, ensuring that the framework for population health is delivered effectively.

Care will be needs-based, will include flexible access to advice and support for 'healthier' sections of the population, as well as joined up multidisciplinary care for those with more complex conditions. There will be a focus on population health including well-being, prevention, self-care, self-access, signposting, and supporting people to make choices about their care. There will also be a drive to improve the work life balance of people who work in general practice, through networks of practices and teams that bring community and primary care teams together to focus on neighbourhoods.

West Sussex is well set up to support the development of PCNs, learning from the work done over the last few years in developing Local Community Networks (LCNs) and Communities of Practice (COP). In preparing to provide the network services from April 2020, our PCNs are focusing on developing their teams through piloting a range of integrated services such as wound care and leg ulcer clinics. By doing this, PCNs will have built up their capacity to provide the network specifications once they are published in early 2020. Our plans for the development of services in support of these specifications assumes that we will achieve full delivery of the Network DES by the beginning of 2021/22 and that PCNs will be in a position to participate actively within ICPs and be ready to operate as providers in their own right by the end of 2020/21.

The Network DES requires practices to set themselves up as PCNs with a nominated bank account, a Clinical Director, and a signed agreement between the network practices. All practices in West Sussex have met the DES requirements and are providing Extended Access hours as a PCN. A number of PCNs have employed clinical pharmacists and social prescribers. Our Clinical Directors have met as a West Sussex group and have committed to share good practice. We also have a clinicians' advisory group that focuses on supporting Clinical Director and PCN development.

4.3 Urgent Care

4.3.1 Overview

The NHS LTP includes a significant package of measures aimed at reducing pressures on A&E departments. Many of the measures build on previous initiatives, including the introduction of clinical streaming at the front door to A&E and the roll-out of NHS 111 services across the country.

The model for urgent care in West Sussex has been developed over time with engagement across partners, including patients and public. It has adapted as the national steer has become clearer, particularly around NHS 111 and Out of Hours (OOH). The national specification for Integrated Urgent Care (IUC) was published in August 2017 and mandates NHS 111, clinical assessment services (CAS) and Home Visiting to be procured together to ensure integrated provision and a better experience for people. The model has been adapted and a wider programme is in place which includes commitments set out in the NHS LTP to:

- Roll out urgent treatment centres (UTCs) by April 2020 so that urgent care outside hospitals becomes more consistent
- Improve the advice available to people over the phone and extend support for staff in the community by introducing a multidisciplinary CAS as part of the NHS 111 service in 2019/20
- Rapid improvement in access to urgent care pathways to address issues impacting upon constitutional performance
- Consistent provision of same day emergency care (SDEC)
- Improved outcomes for those with mental health problems presenting in crisis, focused on resilience in communities and in alternatives to admission to hospital
- And opportunities to free-up acute hospital beds, including greater investment in discharge to assess (D2A) and greater levels of reablement

4.3.2 Integrated urgent care

A great deal of work is underway to improve the responsiveness of our community services. Our ambition is to provide safe, high-quality care to our population, operating as a fully bookable service, and placing greater emphasis on the use of alternative supporting services for minor injuries and ailments.

In West Sussex we have committed to rolling out UTCs by April 2020. UTCs will be GP-led facilities and will include access to some simple diagnostics and offer appointments bookable via NHS 111 for people who do not need the expertise available at A&E departments. They will be introduced at both Worthing and St. Richard's Hospitals by December 2019 and will be fully compliant with national standards from April 2020. Crawley will remain as a UTC, meeting national standards by December 2019. Bognor, Horsham and Queen Victoria Hospitals will become integrated primary and urgent care sites with an expectation that a model for these services will be agreed and fully operational from April 2021.

Alongside this, we will improve the advice available to people over the phone and extend support for staff in the community by introducing a multidisciplinary clinical assessment

service (CAS) as part of the NHS 111 service to be introduced in West Sussex from April 2020.

We will also support PCNs and developing ICPs to deliver a wider framework for community based urgent care, designed to increase the number of people receiving treatment in the out-of-hospital setting, through:

- Improved access to GPs and other local clinicians through clinical navigation hubs
- Increased community diagnostics to reduce demand on hospital-based diagnostic services
- A paramedic practitioner model supporting patients to be seen at home and reducing the need for conveyance to hospital
- Improved response for people with mental health problems including crisis cafes and safe havens to divert those in a crisis from unnecessary attendance at A&E
- Delivery of recommendations for our ambulance services further to the recent review of operational performance led by Lord Carter

A comprehensive delivery plan for further improving community response in a crisis and setting out our priorities for delivering this will be established by September 2020 as part of our joint delivery plan.

4.3.3 Same Day Emergency Care

Our A&E departments in West Sussex will introduce SDEC or ambulatory emergency care. This will see some patients admitted from A&E undergo diagnosis and treatment in quick succession so that they can be discharged on the same day, rather than staying in hospital overnight. Nationally, the NHS LTP estimates that up to one-third of all people admitted to hospital in an emergency could be discharged on the same day by rolling out this model.

SDEC services treat a wide range of common conditions including headaches, deep vein thrombosis, pulmonary embolus, pneumonia, cellulitis, and diabetes. The types of conditions that can be managed through SDEC will vary depending on the hospital and needs of the local population.

In West Sussex we will:

- Provide SDEC services at least 12 hours a day, 7 days a week by the end of March 2020
- Provide an acute frailty service for at least 70 hours a week by the end of March 2020, working towards achieving clinical assessment of frailty within 30 minutes of arrival in hospital
- Establish a ‘Rapid and Early Assessment for Cardiac Treatment’ (REACT) service and day-case angioplasty (PCI) service at Worthing and St. Richards Hospitals to reduce admissions and prevent clinically unnecessary overnight stays from December 2019

4.4 Ongoing Care Needs

4.4.1 Overview

PCNs will develop multi-agency teams to provide integrated care and support for people with ongoing care needs. The first priority for these teams is to develop high quality care plans for

people identified as having severe or moderate frailty. PCNs will be supported to deliver this integrated approach with data solutions designed to enable segmentation and risk stratification.

A programme of work has also been established across West Sussex to support more people in their own homes or in a community setting. This programme includes:

- A responsive service community model to deliver “Home First” and D2A provision
- Rapid response for admission avoidance and early supported discharge (ESD) for those who have had a stroke
- Acute and community teams working with social care and the voluntary sector to improve patient flow through hospital
- Improved support to care homes to reduce the number of residents who are taken to hospital and admitted as emergencies

4.4.2 Step Up Step Down

Improving patient flow and reducing delayed discharges remains a priority in West Sussex. Alongside ongoing initiatives such as “Trusted Assessment” and the “Let’s Get You Home” campaign, a programme has been established which sets out a Step Up Step Down (SUSD) model for West Sussex designed to support delivery of an integrated discharge and admission avoidance service covering 6 weeks prior to and post an acute episode combined with single streamline access.

The vision is to deliver an integrated health and social care team with the right skill mix to maintain people in their own homes avoiding acute hospital admission when possible as well as discharging patients with the appropriate support following admission. This will consolidate available resources across health and social care to place people at the centre of service delivery. An integrated team should enable skill development, cross cover and support between current disparate teams.

For the purposes of this programme, SUSD services are defined as specific community based health and care services and interventions which work directly to achieve one or more of the following objectives:

- Acute admission avoidance at the point of clinical need for acute care
- Early supported discharge after acute admission
- Longer-term avoidance of unplanned hospital admission
- Reduction in the use of home care services
- Avoidance of admission to long term care

The model will be delivered in three phases as follows:

- **Phase 1** – ‘Step-down’. Consistently deliver the nationally recognised D2A four pathway model (October 2019) and formation of Integrated Discharge Teams
- **Phase 2** - Align 6 weeks post discharge services with joined up front door and admission avoidance services to include:
    - co-location (April 2020)
    - a change of response criteria for all admission avoidance referrals to be classified as urgent with a target of phone or visit within 2 hours (April 2021)

- alignment of referrals to a single point of access (SPoA) (April 2021)

- **Phase 3** - Provision of fully integrated SUSD services (January 2021)

We have defined short, medium and long term aims (2022/23 onwards), all of which align to the overarching principle of delivering sustainable community crisis and reablement services for the next 10 years. We expect that our plans will:

- Reduce functional decline and improve outcomes for those requiring inpatient care
- Improve flow and increase weekend discharges by 25%
- Increase the number of people returning home directly from hospital
- Reduce length of stay for complex frail patients

Within the scope of this programme we will also work to understand the capacity and demand for a West Sussex community health crisis response service and a reablement service and the alignment of both initiatives to standardised metrics. This analysis will be completed by February 2020.

Developing Enhanced Health in Care Homes

Plans for PCN development across West Sussex includes provision of enhanced health in care homes (EHCH) from April 2020.

A range of support for people in care homes has been developed over recent years as follows:

- Locally Commissioned Services (LCSs) where GP practices receive additional payments to provide an enhanced primary care service
- Community nursing support providing training for care home staff; targeted support for homes identified as having higher needs; specific support designed to reduce unplanned admissions and 999 calls; training around end of life identification; and care homes are being supported to register on NHS.net
- Pharmacists who provide medication reviews for residents of care homes

To deliver EHCH and to improve this core support offer, we are developing our Proactive Care MDTs to support integration with general practice. This model:

- Defines a target population of frail and elderly in receipt of integrated multi-disciplinary care (inclusive of care-home residents, in line with requirements of EHCH framework)
- Devises a system by which the target population is consented into community MDTs
- Defines a set of proactive interventions to be delivered by general practice and community MDTs
- Requires general practice and community MDTs to develop a system for organising more accessible and coordinated community response to those with escalating needs
- Aligns both operational requirements and incentives between Sussex Community Foundation Trust (SCFT) and practices to create a framework for integration around PCNs
- Aligns with the current LCS for care homes

4.4.3 Falls Prevention

Falls prevention is one of the priority areas in the Ageing Well component of our Health and Wellbeing Strategy. Therapeutic strength and balance exercise programmes are the key intervention for those at low to moderate risk of falls and an important part of the treatment of those at high risk. They have been shown to reduce the number of falls by around a third and the number of people falling by a fifth. Group strength and balance has also been shown to increase overall levels of physical activity and can reduce loneliness and social isolation. At the same time, interventions can be delivered improving the opportunities for strength and balance promoting physical activities ranging from ball and racquet sports to muscle strengthening activities using free weights, bands or machines. There is also the opportunity to support an increase in strength and balance in activities of daily life.

Currently all West Sussex districts and boroughs deliver strength and balance exercise programmes and leisure services provide a range of physical activity opportunities. The ambition is to continue to increase quality and integrate strength and balance for falls prevention into an overarching physical activity framework for mid and later life.

4.4.4 A Carer-Friendly NHS

Support to carers in West Sussex centres around the “Joint Commitment to Family, Friends and Carers 2015-2020”. This is supported by:

- The Family and Friends Carers’ Care Pathway which provides a generic pathway for incorporation into all patient and customer care pathways and hospital admission/discharge procedures, to help health and social care staff in identifying, recognising and supporting carers
- Carers Support West Sussex which provides county-wide advice, information and support to adult carers, is the reception point for all carers’ services in West Sussex, and enables carers to access relevant support services
- The Carers Health Team, which supports carers over the age of 18 to develop individual strategies with an aim to reduce the strain of coping with their caring role and, if it is necessary, also look at the health needs of the person who is being cared for and the bereaved

Through our joint delivery plan we will raise the profile of carers, achieve personalised support to carers, ensure young carers can achieve education and employment, support carers to remain physically and mentally well, and build a carer friendly community.

4.4.5 Respiratory

West Sussex has developed plans to improve the delivery of respiratory care, by focusing on respiratory care in the community.

In the north of West Sussex a plan has been set out to redesign respiratory pathways. The aim of these pathways is to ensure that that admissions from respiratory conditions can be reduced by effective management of different levels of complexity across primary care, general and specialist community services.

In Coastal West Sussex (CWS), a comprehensive community respiratory service is being implemented. The first phase, implemented in 2019/20, will see Home Oxygen Assessment and Review becoming available to all patients receiving long term home oxygen. Phase two will explore a redesign of the current COPD and pulmonary rehabilitation service. Longer term, our aim is for the service to be able to provide community support to people with a

wide range of respiratory-related conditions, reducing the need for these people to have to travel out of the area for specialist aftercare.

4.4.6 Personalised Care

The NHS LTP expects systems to set out how they will use the funding available to them to implement the six components of the NHS Comprehensive Model for Personalised Care as set out in Universal Personalised Care.

Personalised care is increasingly important as our population want more choice and are often experts in their own care. They expect clear information about what treatment involves, the evidence that it works, the outcomes it will achieve and what happens next. Across West Sussex there are plans in place to deliver many of the six components of the NHS Comprehensive Model for Personalised Care. This includes:

- **Shared decision making** - a focus on establishing shared decision making for elective care services including Musculo-skeletal (MSK) services as a priority first step and work with LAs to further develop plans for those with a LTC and/or in need of continuing health care
- **Personalised care and support planning** - plans for personalised care and support planning to be developed with local authorities within the framework of the F.A.C.E. model
- **Enabling choice, including legal rights to choice** – with a focus on developing and enhancing a single referral pathway, a referral support service for elective care, and designing follow up services that allow patients to opt in and out as their needs change options
- **Social prescribing and community-based support** – building on existing social prescribing initiatives with a coherent social prescribing approach aligned for the whole of West Sussex
- **Supported self-management** – we will use digital solutions such as MSK Assist to support people to build knowledge, skills and confidence and to live well with their health conditions. We have introduced a pilot project in partnership with NHSE/I and local providers to test the value and efficacy of supported digital self-management. The allocation of NHSE funded myCOPD online subscription licenses will be offered free, by NHS clinicians, to eligible patients with COPD. Evaluation outcomes include:
    - Improving knowledge, skills and confidence to self-manage their long term condition
    - Improve health outcomes, including reducing exacerbations
    - Improve local health economy outcomes, by reducing avoidable GP appointments and avoidable emergency admissions
- **Personal health budgets (PHBs) and integrated personal budgets** - spending more on PHBs in 2019/20 compared to 2018/19; provide training for PHBs; and increasing work with the LA to develop their plans to increase the number of PHBs

There is also work to be done in conjunction with LAs to develop and agree a detailed set of deliverables for the NHS Comprehensive Model of Personalised Care as part of our joint delivery plan. There is work in place to ensure that PCN members are aware of each other's role and responsibilities in relation to delivering these services, and there will be a workforce plan within each PCN to review capacity, skills and support needed to deliver the new services as a network.

4.4.7 Elective care

We will also begin the process of redesigning our elective care services. This programme will focus on:

- A review of pathways for major diseases and long term conditions
- New integrated pathways in areas such as MSK, which will redesign the relationship between GPs and secondary care clinicians to one where it is easy to get advice in real time and to improve care earlier in the pathway
- Minimising activity with limited clinical value in line with the Clinically Effective Commissioning (CEC) programme and Low Priority Procedures (LPP) guidelines and policies
- Improving referral support for GPs
- And enhancing the productivity of acute and out of hospital planned care capacity – through virtual clinics, direct to test referrals, one-stop clinics and clinical hubs, and ensuring effective treatment first time to avoid the need for follow up appointments

West Sussex is currently piloting First Contact Practitioners (FCPs) for MSK, and we plan to roll out services across the county from April 2020.

Outpatient Redesign

The NHS LTP includes an ambitious pledge to use technology to fundamentally redesign outpatient services over five years. The aim is to avert face-to-face consultations in order to provide a more convenient service for patients, free up staff time and save money against the expected growth in demand.

The plan requires systems to set out how they will increase the use of digital tools to transform the ways in which outpatient services are offered and provide more options for virtual outpatient appointments. System partners in West Sussex have committed to working together to deliver an outpatient transformation programme.

Our programme recognises there are opportunities to deliver transformation at all key touch points in the patient's elective care pathway including advice and diagnosis, follow up care after a hospital procedure and ongoing specialist care for long term conditions.

Some outpatient redesign pilots are under way for a limited number of specialty areas and these will be evaluated on an ongoing basis. We will be working with providers to identify which specialties will be prioritised across 2020/21. We know that Western Sussex Hospitals NHSFT (WSHFT), for example, will prioritise orthopaedics, urology and ophthalmology. This process will be complete by March 2020 and we will establish a programme of work which will see the implementation of one stop and straight to test pathways, virtual clinics, SOS follow up and the use of alternatives such as telephone or Skype. This process will also include modelling to assess the impact of a reduced number of face to face visits, to include an assessment of capacity against expected growth over the next 4 years.

More specifically we will see:

- The first stage implementation of digital outpatients by providers during 2019/20, deploying access to letters and appointments through an STP-wide Personal Health Record solution.
- Development and implementation of a Sussex Wide Dermatology service

- Conclusion and implementation of the of the Sussex Wide Head and Neck Review
- An integrated MSK model for CWS including a single point of access with clinical triage, shared decision making, promotion of conservative treatment options in line with CEC policies and supported self-care enabled by digital solutions such as Patient Know Best
- A recurrent service model following evaluation of the Virtual Fracture Clinic pilot at Surrey and Sussex Healthcare (SaSH)
- Transformation of ophthalmology pathways including AMD and glaucoma
- A pathology optimisation programme consistent with “Choosing Wisely” principles to reduce the number blood tests identified as either of limited clinical benefit, not required, should only be consultant initiated or requiring specific intervals between tests
- Provider implementation of the opportunities identified by the FourSight Theatre Efficiency programme in ophthalmology, general surgery and ENT

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

Cutting waits for elective care

In West Sussex, the time that patients have waited for elective treatment has increased and we are not compliant with NHS constitution targets. This has been one of the most difficult operational issues over recent years, impacting on the experience of many patients waiting for treatment.

We will develop a demand and capacity plan by the end of December 2019 showing how, over 5 years, a combination of the system efficiencies and transformation programmes outlined above, and increases in the volumes of some planned activity will reduce long waits and cut the number of people on the waiting list.

We will aim to improve patient experience, quality and responsiveness of elective provision to:

- Expanding the scope and uptake of Advice and Guidance on E-RS and working with providers to agree service specifications and response times and that consultant time to respond is reflected in job plans
- Delivering the next phase of clinical policy development via our CEC programme which aims to ensure access across Sussex is consistent, in line with the latest clinical evidence and represent the most sensible use of limited resources
- Working within the national Evidence Based Interventions (EBI) Demonstrator community to ensure effective implementation of relevant national Evidence Based Interventions and their next phase of policies
- Working across Sussex to implement a system wide solution for prior approval to deliver overall reductions in the number of interventions not routinely provided and improved adherence to evidence based clinical policies.
- Exploring how to establish community diagnostic and training centres for X-ray, CT, MRI, ultrasound, and bone scan and barium swallow services.
- Continuing to focus on demand management, through:

- Implementing the “Capacity Alerts” system
- Further development of our referral support service, including peer review via PCNs
- Improving referral support for GPs

- Implement a single referral pathway for all specialty areas by the end of 2020/21

We will take a Sussex-wide approach to offer choice of alternative provider to patients who have been waiting more than 26 weeks. A Sussex Delivery Group has been established, including commissioners and providers, to develop a Standard Operating Procedure, source capacity and set up a central ‘administrative hub’ to manage the process. We expect to be able to commence a small scale pilot in December 2019, roll out of priority specialty areas for some patients in January 2020, with full implementation for all providers for all pathways by March 2020.

We will also take specific actions to enable achievement of the diagnostic standard including:

- a demand and capacity review of non-obstetric ultrasound and implementation of a single delivery approach across Sussex by end of 20/21
- Implementation of a revised threshold for faecalprotectin resulting in fewer face to face appointments and endoscopies
- extending the scope of FIT tests to include high risk patients resulting in decreased demand endoscopy through an initial pilot in CWS
- Working with the Cancer Alliance to deliver Rapid Diagnostic Services

Planned NHS-Managed Choice Process

The NHS LTP requires systems to implement a planned NHS-managed choice process for all patients who reach a 26-week wait. In West Sussex, the NHS-Managed Choice Process will be fully implemented for all providers and for all pathways by March 2020. This will be a commissioner responsibility and the CCGs will review Referral to Treatment (RTT) 25 week waits on a monthly/fortnightly basis.

This will be supported by the referral support service in the north of West Sussex and the single referral pathway in CWS, which both contain functionality to ensure that all patients waiting more than six months for their elective treatment are proactively contacted.

4.5 Highest Needs

4.5.1 Overview

Our neighbourhoods have a small number of people whose needs are greatest and who require high levels of care and support. These people will also have a high quality care plan and will be supported by a local MDT team which may operate across more than one PCN. Specialists will have a direct role in care planning and delivery and will also have an important role in supporting the wider team with training, advice and support.

When people require inpatient care the aim is to maintain continuity with the local specialist team through in-reach, communication and joint planning, to minimise the time people need to spend in hospital and ensure safer discharge.

4.5.2 Providing 'Anticipatory Care'

In the north of West Sussex we have developed COP which are providing elements of anticipatory care for a defined population. These are MDTs that provide wrap around community support to the most frail populations. Latterly, these teams have re-configured around PCNs.

Within the Network DES for PCNs, GP practices and other providers of community services will work collaboratively to introduce more proactive and intense care for people assessed as being at high risk of unwarranted health outcomes, including people receiving palliative care. Our plans for PCNs set out an intention to deliver the specification for anticipatory care from April 2020 within the framework of the F.A.C.E. model (Find, Act, Care, Evaluate) set out at Figure 7 below.

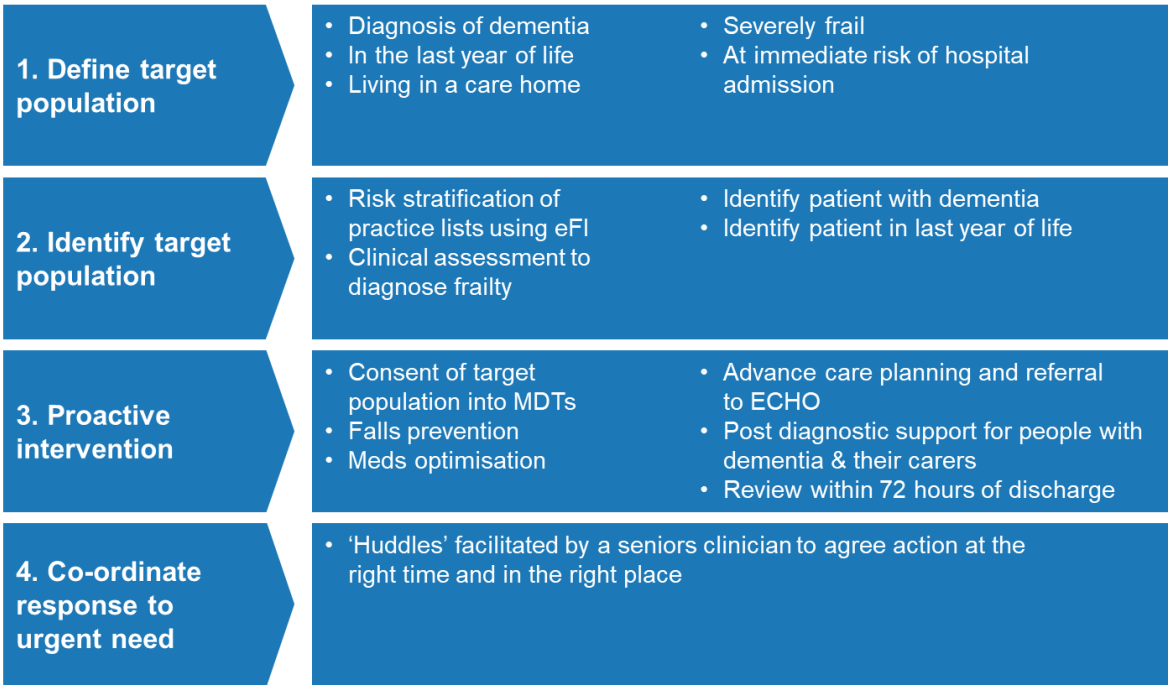


Figure 7: FACE Model

4.5.3 End of life care

End of Life Care (EOLC) continues to be an integral part of our priorities for West Sussex.

Our Health and Wellbeing Strategy includes the goal that people in West Sussex receive good quality end of life care and have a good death. The aim is to build compassionate communities across the county, where people are able to have conversations about living and dying well and to support each other in emotional and practical ways in times of crisis and loss. We need to work together with our partners across the county if we are going to make this a reality.

Many people whose deaths are predictable are not being identified as being in the last year of life. This means that their care needs are often not being met or identified. This may lead to avoidable use of emergency inpatient care and a significant proportion of EOLC patients dying in hospital. There is also evidence that a large percentage of the care home population is in the last 2 months of life, yet care homes are not always consistently able to manage deterioration and dying patients.

Compassionate communities are an asset-based approach to EOLC developed with communities themselves. They support people who are dying and their families, as well as people who have been bereaved, and improve people's health and wellbeing at times of crisis and loss. They help people to plan ahead and make choices, talk more openly about death, dying and bereavement, and care for people at the end of life and after death. Compassionate communities do not replace health and care services but work together with them to enable people to have a good life till the end and a good death.

In West Sussex we have many assets which we can build on – including our hospices which are delivering elements of this approach, Gold Standard Framework-accredited care homes, dementia-friendly communities such as Crawley, the ECHO hub in the south of the county, a strong voluntary and community sector, and increasing identification of people in the last year of life in primary care.

Our initial scoping work has identified the need for community engagement as a priority to understand people's views and experiences of death, dying and bereavement, and what a compassionate community means. Over the next 12 months our focus will be on 3 work streams: community engagement, stakeholder engagement, and identifying resources and capacity to deliver the work programme.

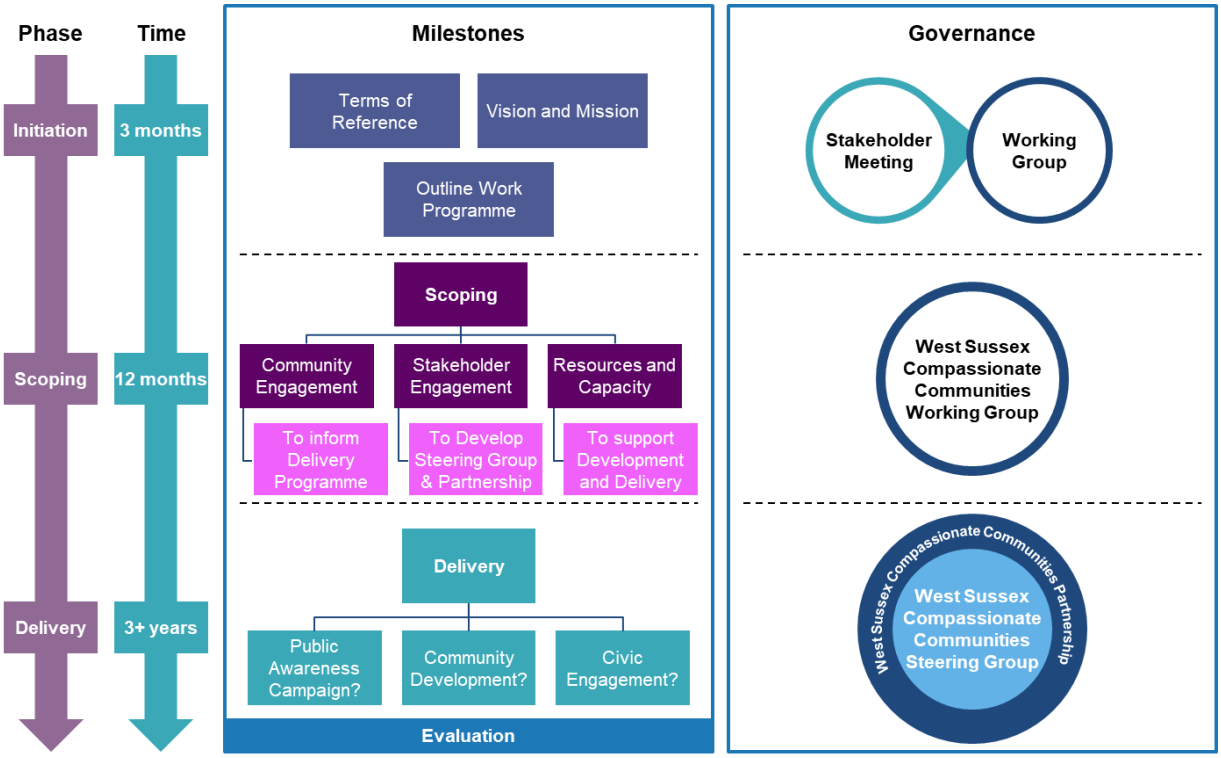


Figure 8: Compassionate Communities work programme

Building on the success of ECHO (83% of ECHO patients with a known preference died in their preferred place) we will also continue to improve care for those in the last year of life and their carers by:

- Increasing timely identification of the end of life care needs
- Reducing the rate of short-stay non-elective admissions in the last 12 months of life
- Reducing the proportion of deaths occurring in hospital

To do this we will develop a programme of work by March 2020 to:

- Expand our PHBs to those receiving specialist end of life care
- Personalise care, working with patients, families, local authorities and our voluntary sector partners at both a national and local level, including specialist hospices
- Roll out training to help staff identify and support relevant patients, introducing proactive and personalised care planning for everyone identified as being in their last year of life
- Continue to embed the ‘ECHO’ pathway in our emerging PCNs through the FACE model
- Embed the GP QOF QI and participate in PCN activities to regularly share learning
- Deliver improved co-ordinated personalised anticipatory care within primary care
- Continue to embed ‘Planning Your Care’ process across PCNs
- Support development of EHCH by commissioning of relevant skills and training

5 Children and Young People

In West Sussex, we understand that the first few years of life are a key period in which the actions of our parents, carers and those around us influence our physical, emotional and mental health in later life. Our earliest experiences of life, starting in the womb, through pregnancy and birth and into our early years, are vital in laying the foundations for our future health and wellbeing. Research consistently shows that even short term improvements in physical development (i.e. obesity and physical activity), cognitive development (i.e. school achievement), behavioural development (i.e. antisocial behaviour) and social/emotional development can lead to benefits throughout childhood and later life.

In West Sussex, the proportion of children and young people within the overall population has remained relatively stable over the years, certainly in comparison to older people. However, what has changed rapidly is the sort of society and problems that children and young people face, the increase in children being referred to agencies, and the complexity of the children that our services are working with. Our challenge is to adapt to this growing complexity and support parents, carers and families, providing universal services but also targeting resources at those most in need, and those at risk of poorer outcomes, narrowing the inequality gap . This requires systematic approaches to prevention, good communication, appropriate data sharing, working with a range of partners, at all stages of childhood, and in a range of settings.

Our Health and Wellbeing Strategy for West Sussex sets out our priorities for the improvement of services for children and young people (CYP) with a focus on a “start well” approach. Our goals, as set out in the strategy are as follows:

- **Improved infant and maternal outcomes especially in deprived areas** - we can help ensure the best start in life for babies by working to reduce smoking in pregnancy and to address the causes of low birth weight, infant mortality and poor maternal mental health
- **Children, young people and families have good emotional wellbeing and mental health** - we will support children, parents and carers to achieve and maintain good mental wellbeing and to reduce mental health problems
- **Children grow in a safe and healthy home environment with supportive and nurturing parents and carers** - parenting is critical to children’s experience of early years and their life chances. We will work to support parents in creating a healthy and safe home and learning environment that nurtures their children, to ensure strong parent-child attachment and positive child development, as part of our parenting offer
- **Children and young people leaving care are healthy and independent** - we will work to ensure comprehensive pathways and care packages are available to support care leavers.

The key initiatives supporting delivery of our strategy are:

- Sussex and East Surrey Local Maternity System Transformation Plan– set up to improve services and support for pregnant women, babies and their families
- 1001 Critical Days: Vulnerable Pregnancy Pathway – delivering a connected multi-agency vulnerable pregnancy pathway and new guidance
- Whole schools approach - to build resilience and improve health and wellbeing outcomes for all pupils

- Healthy Child Programme - framework of universal and progressive services for children and young people to promote optimal health and prevent ill health
- Find It Out Plus - an integrated hub approach to emotional wellbeing and mental health for young people
- Family Assist - digital support for families pre-birth to 19 years (25 years SEND). Currently focuses on pregnancy to 2 years
- Corporate parenting - everyone working with, or representing the interests of children and young people in care is a corporate parent. All local authority staff, elected members and relevant partner agencies share this duty
- Sugar reduction - working alongside other initiatives to tackle childhood obesity
- Apprenticeship scheme - support the development of an apprenticeship for care leavers

We know that there are gaps in the current provision of NHS children's services across West Sussex that are currently being supported by temporary arrangements that are not sustainable. We have workforce constraints; pathways into and out of services that are not always clear; we have no formal arrangements for acute commissioning; our multi-organisational working is in need of development and creates the potential for fragmentation; our leadership for strategic development is unclear and our plans are not adequate. Our priorities for the next 12 months, therefore, will be:

- Developing a shared improvement plan for NHS children's services reflecting commitments set out in the Health and Wellbeing Strategy and showing how we will improve performance in areas such as childhood screening and immunisation programmes and how we will meet the base level standard in the NHS public health functions agreements
- Developing a clear strategic plan including an understanding of investment and resources and our priority areas for change to ensure delivery of NHS LTP commitments, with a specific focus on:
    - Developing age-appropriate integrated care
    - Integrating physical and mental health services
    - Enabling joint working between primary, community and acute services, and supporting transition to adult services
    - Improving care for children with long-term conditions, such as asthma, epilepsy, diabetes, and complex needs
    - Treating and managing childhood obesity
    - Supporting the expansion of CYPs mental health services
    - Improving outcomes for children and young people with cancer.
- Integrating our offer across both the NHS and LAs to ensure local leadership; an engagement strategy which will underpin co-production with children, young people, families and carers; and a clear view of expectations of our services and the outcomes for children and young people

6 Enablers

6.1 Workforce

People are at the heart of the system that we are building. We recognise that recruiting and retaining our workforce in a geographical area which has a high and increasing percentage of older people, a current workforce with large numbers close to retirement and a decreasing percentage of younger people joining the workforce, is a critical issue both now and in the future. With these anticipated demographic changes we will have to think strategically and differently to ensure that we have the workforce we need to deliver care. This will require us to think creatively about roles and ways of working. Refining our workforce plans to ensure a sustainable workforce aligned to our vision is therefore a priority, alongside developing a framework in which strong leadership creates a culture where people want to stay, thrive and develop.

The NHS LTP calls for a 'fundamental shift' in the way that the NHS works alongside people. With leadership from WSCC, we will focus on developing an assets-based approach to creating genuine partnerships between professionals and people in receipt of care and support, and we will establish a programme to train staff to be able to have conversations that help people make the decisions that are right for them.

Our local priorities are based on the need to support sustainable delivery today, and strengthen the foundations and planning that will enable the workforce to support and deliver the vision for the future. The key elements of our work programme in West Sussex are:

- Partners working together to identify and resolve immediate workforce pressures and opportunities to stabilise the current system in West Sussex. This includes reducing the use of temporary staffing, working on urgent issues such as GP recruitment, and work place wellbeing initiatives, including tackling burnout
- Supporting the vision for West Sussex through workforce modelling and planning that will enable us to refine current plans to redirect our focus and work to deliver at scale and pace, in relation to both the capacity and capability of the collective workforce
- Developing a Workforce and Organisational Development Strategy by September 2020 to support our joint delivery plan, which will describe how we will support the transition and establishment of new ways of working and describe how we will support and develop individuals and teams that can work together to deliver the new care model
- Developing the conditions for change with a communications framework to truly engage and enthuse our staff
- Designing a workforce development programme that will enable the leadership needed to deliver real change and to develop people in line with our vision

6.2 Digital and IT

Digital technology underpins some of the NHS LTP's most ambitious patient-facing targets and is a key enabler to the delivery of the new models of care, supporting staff to work differently, improving access to advice for patients and the public, harnessing data to inform decision making, and through telehealth solutions, driving productivity improvements. Patients have also told us that they increasingly expect to be able to use digital technology to interact with health and care services. Digital technology will also facilitate service transformation, including the redesign of outpatient services and reorganisations of pathology and diagnostic imaging services.

The development of a shared care record is an immediate priority in West Sussex and one which will support delivery of the commitment that people will be able to access their care plan and communications from health professionals and support the "right" set out in the NHS LTP for people to have access to digital primary care services. The shared care record will also support the following functionality:

- Provision of a shared record viewer so that authorised health and social care workers can see relevant care data from GPs and all other care providers at the point of care
- Support for the development of care plans and common assessments to be used and shared by the entire care community
- Support for clinical alerting and decision support across care providers
- Task management, clinical communication and referrals across care communities so that clinicians can ask for advice or support on-line
- Risk stratification and segmentation

To deliver 'digitally enabled care' as envisaged by the NHS LTP, we will work across Sussex to deliver a wider programme ensuring that all secondary care providers become 'fully digitised' by 2024. West Sussex will also deliver digital transformation of primary care. It is a key deliverable that all GP practices are technically enabled to provide all the functionality that will be offered through the NHS App, as part of the Digital Primary Care transformation plan to ensure it is available to 100% of the population by 31 July 2019.

Our specific priorities for digital transformation over the next 2 years are:

- Development of a fully interoperable record between providers via the Primary and Secondary Care interface project
- The roll-out of the NHS App, Online Consultations, and online booking into Integrated Urgent Care Services (Urgent Treatment Centres and Extended Access)
- Ensuring robust connectivity between primary care clinicians regardless of them working on a sessional or substantive basis

6.3 Estates

Ensuring that the estate is fit for purpose is key to implementing new models of care. Our approach will be based on the following assumptions:

- Elements of the current local healthcare estate, in particular GP and community premises, are becoming increasingly less suitable for delivering the new care model, and are increasingly expensive to run and maintain. To 'do nothing' with the estate is not a sustainable option.

- New models of care involve greater integration and co-ordination amongst a wider range of services, which impacts directly on the estate requirements of those services.
- Co-location and delivery of services at an optimised scale will bring significant benefits to the population in terms of shared facilities and resources in an accessible community location.

Our estate plan for West Sussex will seek to:

- Improve the suitability, quality and utilisation of the estate
- Dispose of surplus assets to support further re-investment in local care
- Rationalise the estate in ways which support wellbeing, effective networking, co-operation and integration of skills and resources
- Replace outdated, unsuitable and inefficient buildings and ways of working, with modern, flexible and effective work and care settings
- Reduce the environmental impact of the estate

6.4 Communications and engagement

The NHS is an institution that people trust. People have interacted with the NHS in similar ways since 1948, and we are asking staff, patients, carers and communities to change how they do that. This is a huge change and communicating what is happening, and when; and ensuring we are engaging with people is going to be vital in the delivery of the new care model.

Our plan is informed by the Sussex-wide “Our Health, Our Care, Our Future” public engagement. The key issues for West Sussex arising from this are:

- The large geographical area in West Sussex includes both urban and rural populations, some of which have health inequalities that need to be addressed
- A lack of transport in rural areas to support access
- Concerns over GP premises as some are of poor quality and unsuitable for disabled access
- Lack of awareness of urgent care options, including Improved Access
- Varying degrees of willingness to disclose mental health issues and subsequently access support
- The need for cultural awareness and service provision that reflects this
- A need to talk more openly about death and end of life care
- Issues with access to mental health support for children and young people
- Widespread support for social prescribing, and the need to build on and publicise existing assets in local communities

The next phase of our strategy is to develop a clear, compelling and credible narrative that will enable us to engage more widely with stakeholders. It will include independent facilitated focus groups with key audiences to:

- Create an early, important opportunity to begin a wider conversation with stakeholders involved in delivering the new care model

- Help us test our key messages about the new care model
- Give us insight on improvements` that our services need to make for local people
- Provide a platform for a wider programme of engagement with the public and other key stakeholders over the next six months and beyond.

We will use the insight from the focus groups and all the local data available to create a detailed and robust communications and engagement activity plan.

Sussex
Health and Care Partnership

Brighton & Hove Response to the NHS Long Term Plan

Delivering the NHS response as part of our Joint Health and Wellbeing Vision for our Population

Paper for the Brighton & Hove Health and Wellbeing Board

November 2019

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

WHAT IS THE BRIGHTON & HOVE PLAN?

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

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

Brighton & Hove City Council

NHS Sussex Community NHS Foundation Trust

NHS Brighton and Sussex University Hospitals NHS Trust

NHS Brighton and Hove Clinical Commissioning Group

Community & Voluntary Sector

healthwatch Brighton and Hove

General Practice

NHS Sussex Partnership NHS Foundation Trust

3. The Brighton & Hove plan sits alongside the **Sussex Strategic Delivery Plan**, which responds to the Sussex Population Health Check and covers aspects where the **highest quality care and outcomes for the population & patients** can be delivered through planning at a Sussex-wide level

4. We are meeting the needs of our local population and the national ambition of the NHS Long Term Plan in the local context of **growing demand for health and care** meaning services are under extreme pressure and people have to wait, **financial challenges**, a **workforce gap**, and existing **health inequalities**

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

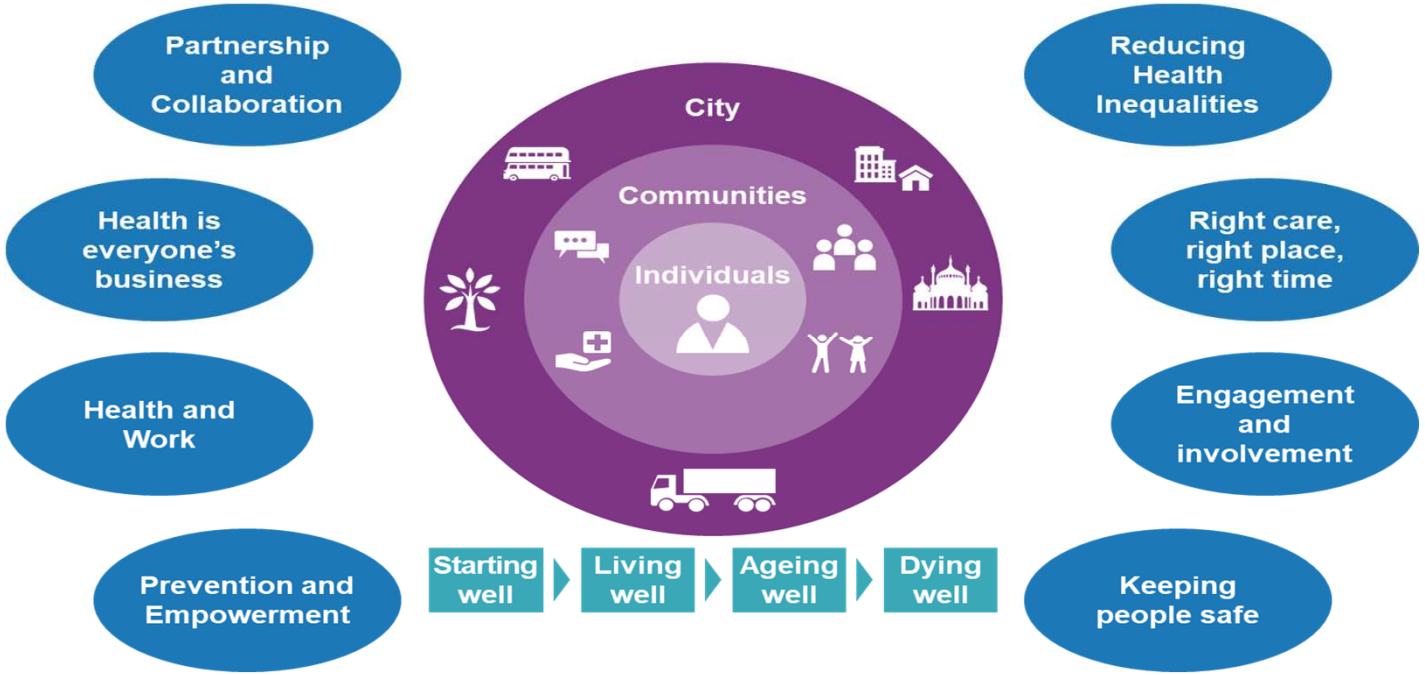
WHO HAS INPUTTED TO THE BRIGHTON & HOVE PLAN?

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

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

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

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



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

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

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

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

Start Well

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

Live Well – Personalisation

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

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

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

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

Live Well

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

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

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

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

Age Well



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

Die Well



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

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

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

WHAT ARE THE KEY RELATIONSHIPS IN BRIGHTON & HOVE?

1. **Working together** as organisations supports the patients and wider population to have a **seamless experience of health and care** where the most **appropriate care is provided quickly**, moving **away from fragmented care** where the focus is on treating episodes of ill health rather than the cause of illness or preventing illness in the first place.

2. We will be changing **how organisations work** to allow health and care provision to be most appropriately tailored to local needs:

   - Sussex is working towards becoming an **Integrated Care System**, a partnership of health and care organisations working together to provide overall assurance for the Sussex health and care system, provide a forum for strategic oversight, facilitate collaboration and joint planning on enabling functions including workforce, digital and estates, and plan and commission specialist services where there are clinical benefits to this being done at a Sussex level.
   - Our **Integrated Care Partnership** will be an alliances of health and care organisations working together to plan and provide services for the population in a consistent and joined-up way. They **will not** be new organisations and **will not** change the accountability of current providers or their statutory duties.
   - Our seven **Primary Care Networks** are groups of GP practices collaborating with local community services, mental health, social care, pharmacy and voluntary sector teams to provide integrated local health and care for communities – building on the ongoing work in "Cluster 6" which has worked closely with the voluntary sector.

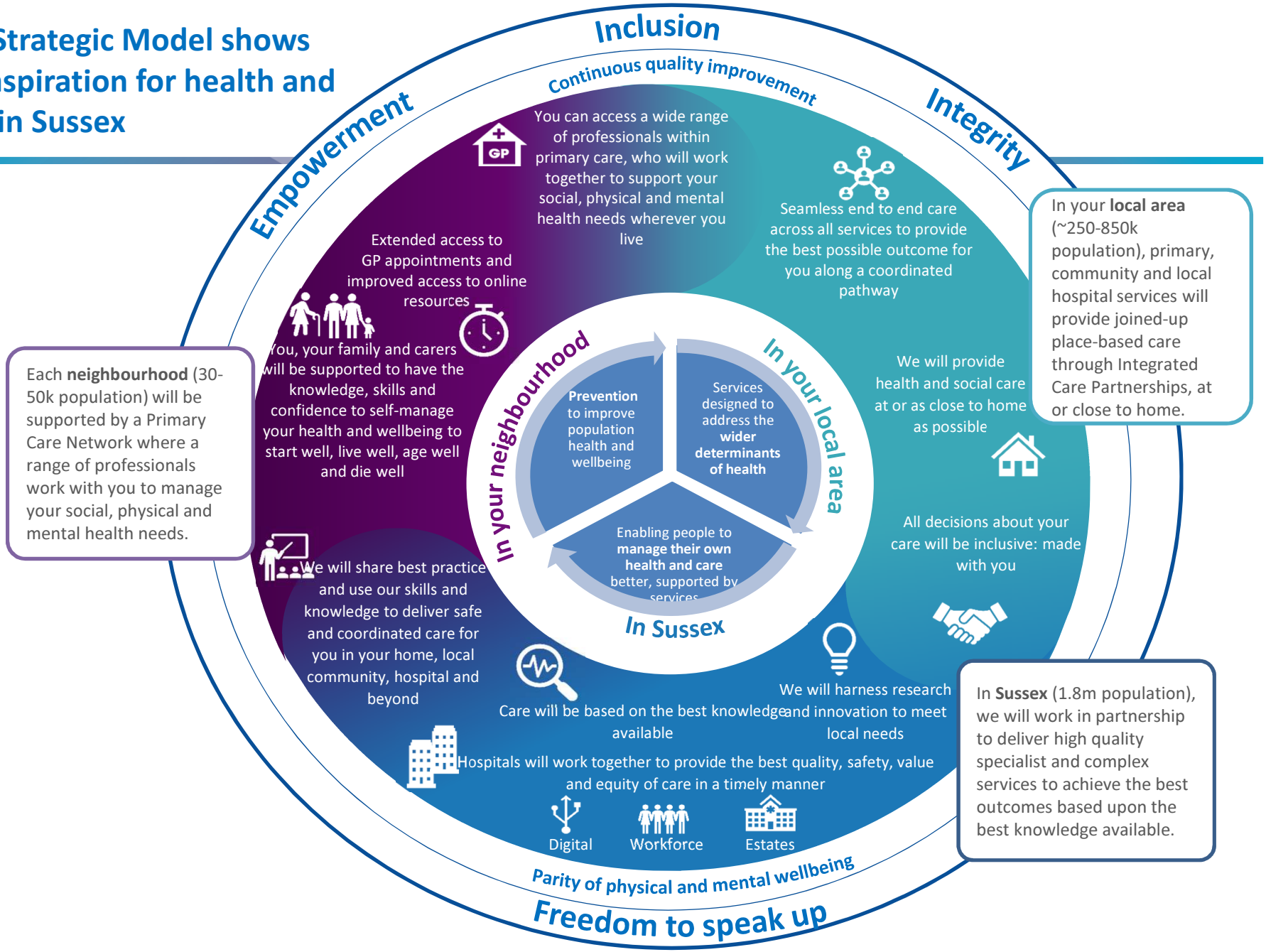
The next steps are to incorporate feedback into the revised plan, submit to NHS England and develop operational plans for 2020/2021

WHAT HAPPENS NEXT?

7 Nov	Comments from all organisations and stakeholders are **drawn together into a revised document**
8 Nov	**Executive review**
15 Nov	**Submission of final plan and technical documents** to NHS England. These will set out the plans and the related impact on finance, workforce, activity and performance for the next five years across Sussex
2 Dec	**Final plan will be published on our website** following any feedback from NHS England
Mid Dec	**National LTP implementation plan published**, which will provide further guidance on how to implement the LTP commitments
Mid Feb	**National submission date for the draft operational plans for 2020/21** (which will operationalise the Local Strategic Plan). These are technical not public documents
End Mar	**Final submission** of 2020/21 operational plans

APPENDIX

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



Each **neighbourhood** (30-50k population) will be supported by a Primary Care Network where a range of professionals work with you to manage your social, physical and mental health needs.

In your **local area** (~250-850k population), primary, community and local hospital services will provide joined-up place-based care through Integrated Care Partnerships, at or close to home.

In **Sussex** (1.8m population), we will work in partnership to deliver high quality specialist and complex services to achieve the best outcomes based upon the best knowledge available.

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

SUMMARY OF HEALTH AND CARE STRATEGIC PLAN INTENT

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

Council	Agenda Item 60 (1)
16 December 2019	Brighton & Hove City Council

NOTICE OF MOTION

LABOUR GROUP

MOULSECOOMB PRIMARY SCHOOL SPONSOR

This council asks the Chief Executive to write to the Secretary of State for Education to outline the following points regarding the proposed academisation of Moulsecoomb Primary School:

1) This Council notes with concern the proposed sponsor (that was selected without any consultation with the governing body or parents), New Horizons Academy Trust's, poor record on improving other schools and wishes to highlight uncovered documents that show that NHAT has already acknowledged that Brighton & Hove Council and current Headteacher at Moulsecoomb is rapidly improving the school[1].
2) This Council stands with and respects the views of the parents, carers, teachers, unions and children of Moulsecoomb Primary. We respect their voice and their opposition to the academisation plan, as evidenced by the 96% parental ballot rejecting it and the subsequent industrial action.
3) This Council notes the local cross-party opposition to these academisation plans.
4) This Council urges Ofsted to reinspect the school, to provide an opportunity to evidence the improvements it has made since the previous inspection.
5) This Council urges the Secretary of State to revoke the academisation order.

Proposed by: Cllr Knight Seconded by: Cllr Childs

Supporting Information:

The Council notes the school's improvement. The council now has a significant amount of evidence of improvement demonstrating the school is not 'inadequate'. This includes improved attendance and outcome data at all key stages. Notes of visits from National Leaders of Education and experienced school partnership advisers comment on improvements in teaching and learning and behaviour for learning. This Council believes that only the Local Authority has the capacity and the resources, including support from Good and Outstanding schools across the city to support this school longer term. This council is confident that the school has improved to the extent that academisation is unnecessary and that a reinspection by Ofsted would reflect this.

[1]https://www.brightonandhovenews.org/2019/11/25/moulsecoomb-sponsor-questioned-school-improvements-newly-released-emails-show/

NOTICE OF MOTION

GREEN GROUP

NHS HEALTH AND SOCIAL CARE DECISION MAKING: DEMOCRATIC DEFICIT

This council:

- Notes that the majority of the NHS England budget is allocated to Clinical Commissioning Groups (CCGs), not local authorities;
- Notes the outcome of the NHS Five Year Forward View, which seeks to give CCGs more influence over the NHS budget;
- Notes that currently, half of the voting members of this council's Health & Wellbeing Board are non-councillors; and
- Notes the opportunity to address this through the comprehensive Health & Wellbeing Board review.

This council requests that as part of the planned review into the Health & Wellbeing Board function, that:

(1) The terms of reference of this Board are amended, to reflect options for providing greater democratic oversight of Health and Adult Social Care decisions; and

That this council agrees through request of a letter or other appropriate means to:

(1) Request that any future government commits to adequately fund adult social care in line with need.

Proposed by: Cllr Shanks Seconded by Cllr Nield

Supporting Information

At a meeting of Health and Wellbeing Board (5.11.19) four representatives of the CCG were able to outvote elected councillors who were seeking to ensure the NHS Long Term Plan was paused pending further public consultation. This, and the restricted power of the Health and Wellbeing Board to monitor and allocate health and social care spend, represents a democratic deficit in the area of NHS and public health spending. Only elected councillors should be given the statutory responsibility for spending public money.

Primary Care: CCGs given more influence over the NHS budget
https://www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing

Future decisions that affect or pertain to local NHS and other health services must be given full, democratic consideration by elected representatives only.

Council	Agenda Item 60 (3)
19 December 2019	Brighton & Hove City Council

NOTICE OF MOTION

LABOUR GROUP

"PARTY HOUSES" – SHORT-TERM LETS

This council

(1) Notes with concern the ongoing issues raised by residents in neighbouring properties to 'party houses', many relating to alcohol abuse, noise disturbance, littering and vandalism. Whilst the vast majority of visitors to our city enjoy themselves without these issues and are very welcome here, we hear residents' concerns and wish to build on previous work conducted by the council in order to take action against the exceptions.

(2) Recognises that it currently does not possess the powers to intervene and regulate these properties, and that this is a problem faced by many local authorities across the country.

(3) Deems it reasonable to request sufficient delegated powers to regulate the commercial lets market in the interests of residents, particularly in tourist destination authorities like Brighton & Hove.

Therefore, this council asks the Chief Executive to write to the Secretary of State for Housing, Communities and Local Government to request the delegation of additional powers to local authorities, in order to allow the regulation of commercial short-term holiday lets, often known locally as 'party houses.'

Proposed by: Councillor Evans Seconded by: Councillor O'Quinn

Supporting Information:

This council is acutely aware of the impact of so-called party houses, which affect tourist destinations and seaside towns and cities in particular.

This council notes previous attempts to address this issue, including cross-party work and a motion calling upon the government to pass national legislation and take action, and regrets that no such action was taken. We note that local authorities currently do not have the ability or the powers to adequately address this issue.

This council now asks for delegated powers so that we can take action where necessary and as appropriate. We need regulatory powers to stand up for our residents and ensure holiday lets are conducted in a responsible way.

Council	Agenda Item 60 (4)
19 December 2019	Brighton & Hove City Council

NOTICE OF MOTION

GREEN GROUP

PROPORTIONAL REPRESENTATION AND VOTER TRIALS

The council notes:

(1) Recent legislation published by the Welsh Government, paving the way for Votes at 16 and Single Transferable Vote (STV) in local elections and notes further that Wales follows the voting method for elections in Northern Ireland and Scotland.

Wales, Scotland, Northern Ireland and the London Assembly all now use proportional systems;

(2) England remains the only country in the UK where local elections are undertaken using the First Past the Post (FPTP) voting system, and, that England is the only country in Europe to use such a system.

(3) The damaging Voter ID trials undertaken earlier this year in the local elections, and plans announced in the Queen's speech to introduce a Photographic ID requirement. Of 44.6M votes in 2017, electoral fraud resulted in 1 conviction or 0.000063%

This council therefore, requests that the Policy & Resources Committee, considers calling for a report detailing the implications of Voter ID on residents in the city and that the report explores the impact of the FPTP electoral system on local elections in Brighton and Hove and how this compares to the popular vote.

Proposed by: Councillor Mac Cafferty Seconded by: Councillor Clare

Supporting Information

LSE studies have found that elections characterised by First Past the Post tend to lead to unrepresentative Parliaments and disproportional representation in Government. This can contribute to wider voter disenfranchisement in politics and

The results of the Voter ID trials from May's elections produced a number of worrying results, including more than 700 voters not returning to vote after being turned away.

Electoral Reform Society Press Release on Welsh Government Legislation https://www.electoral-reform.org.uk/latest-news-and-research/media-centre/press-releases/westminster-looking-ludicrously-outdated-as-wales-pushes-ahead-with-pro-democracy-reforms/

Evaulation of 2019 Voter ID trials
https://www.gov.uk/government/publications/evaluation-of-voter-id-pilots-2019

Announcement on Voter ID in Queens Speech
https://www.independent.co.uk/news/uk/politics/voter-id-photo-uk-government-conservatives-queens-speech-elections-polling-a9154936.html

Ministry ofHousing,
Communities &
Local Government

Cllr Geoff Raw
Brighton & Hove City Council King's House
Grand Avenue Hove
East Sussex
BN32SU

Rt Hon Robert Jenrick MP
Secretary of State for Housing, Communities
and Local Government

Ministry of Housing, Communities & ***Local Government***
Fry Building
2 Marsham Street
London
SW1P4DF

Tel: 0303 444 3450
Email: roberrt.jenrick@communities.gov.uk

www.gov.uk/mhclg

Our Ref: 4416217
Your Ref: BHCC-GR

9th September 2019

Dear Cllr, Raw,

Thank you for your letter of 8 August to the Prime Minister about funding for adult social care. I have been asked to reply as this matter falls within my ministerial responsibilities.

Growing demand for services has meant that all levels of government, including councils, have had to make some tough decisions to balance the books, and I am grateful for the hard work of elected members and officers across the country to make this happen.

I am therefore delighted that the Chancellor has announced the biggest year-on-year real terms increase in spending power for local government in almost a decade.

Next year's settlement for local government responds to the pressures councils are facing by providing access to the largest increase Core Spending Power (CSP) since 2015. CSP is expected to rise from £46.2 billion to £49.1 billion in 2020-21, an estimated 4.3% real terms increase.

We are also able to confirm that all social care grants available this year will continue at least flat in cash terms, which I know was one of the key concerns for councils and the Local Government Association.

Including a £1bn cash grant for social care and a £700m increase in grant funding for children with Special Educational Needs and Disabilities, councils will benefit from having £3.5bn of extra funding available to them for the services that are so important to residents.

Outside of the main Local Government Finance Settlement, local government will also see increases from wider resources made available this Spending Round. The settlement has confirmed a real-terms increase for the Public Health Grant. This means local authorities can continue to invest in prevention and essential frontline health services. The Department of Health and Social Care's contribution to the Better Care Fund will grow in line with the additional investment in the NHS.

This package comes in recognition of the central role that local authorities play in supporting communities and our most vulnerable across the country. We will continue work to make the funding formula fairer and increase the amount of business rates growth which local authorities retain, aiming to implement major reforms in 2021-22.

I hope you will share my view that this is a positive outcome for local government, providing clarity that will support councils to plan your budget for next year but also a significant increase in funding.

As the Prime Minister said on the steps of Downing Street, the Government will set out its plans to fix the crisis in social care once and for all, to give every older person the dignity and security that they deserve. We want to ensure that no one will have to sell their home to pay for care.

We will set out our proposals as soon as possible.

RT HON ROBERT JENRICK MP