Brighton & Hove City Council

HEALTH OVERVIEW & SCRUTINY COMMITTEE ADDENDUM

4.00PM, WEDNESDAY, 18 MARCH 2020

COUNCIL CHAMBER, HOVE TOWN HALL

ADDENDUM

Agenda Item 31

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 22 JANUARY 2020

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Deane (Chair)

Also in attendance: Councillor Barnett, Evans, Grimshaw, Hills, McNair, O'Quinn, Powell and Hugh-Jones

Other Members present: Fran McCabe (Healthwatch), Colin Vincent (Older People's Council)

PART ONE

22 APOLOGIES AND DECLARATIONS OF INTEREST

22.1 There were apologies from the Brighton & Hove Youth Council and from Caroline Ridley, Community & Voluntary sector representative.

22.2 Cllr Siriol Hugh-Jones attended as substitute for Cllr Tom Druitt.

22.3 There were no declarations of interest.

22.4 It was agreed that the press & public should not be excluded from the meeting.

23 MINUTES

23.1 RESOLVED – that the minutes of the 16 October 2019 meeting be agreed.

24 CHAIRS COMMUNICATIONS

24.1 The Chair explained that the local response to the NHS Long Term Plan (LTP), the Sussex Health & Care Plan, was currently being finalised and could therefore not be discussed at this meeting. The definitive plan will be considered at the 18 March 2020, whilst the slot at the current meeting would be used to explore the general principles underpinning the LTP.

24.2 Cllr Barnett informed committee members that she and Cllr Grimshaw had recently visited Lindridge Nursing home to look at the home's rehabilitation beds. She was

pleased to report that she thought that provision is excellent: care was of a very high standard; re-ablement was being offered; the food was very well presented. The dementia beds were also excellent, and in general lots of thought had gone in to making residents feel at home. Cllr Barnett now felt reassured that the closure of the intermediate beds at Knoll House would not have a detrimental impact on rehabilitation. Cllr Grimshaw agreed that the home was really impressive.

25 PUBLIC INVOLVEMENT

25(A) Janet Sang:

25.1 Ms Sang asked the following question:

"My understanding is that each Integrated Care Provider-Partnership central to the Long Term Plan will commission health and social care, and will have a contractually-capped budget based on per capita funding. If that is the case, two issues arise.

Firstly what concerns does HOSC have about the care of those not registered in participating GP practices?

Secondly, what will happen should the needs of the population exceed what can be provided within that budget?

If my understanding is not correct, please explain what is the funding and provision model enshrined in the Long Term Plan."

25.2 The Chair responded:

"I've asked the CCG about this matter and they have informed me that the NHS LTP does not in fact prescribe that commissioning organisations will use a capitated payments model when contracting with an ICP. In fact, there is no prescribed form for the way that partnerships are developed locally outside of ensuring that whatever is delivered is fit for purpose in addressing health inequalities. The focus is on developing programmes for change against some of the identified priority areas and being effective in the way partners in the Brighton and Hove health and care system work together. Any decision made about how partnership working develops will be based upon how best to deliver these programmes; how outcomes can most effectively be improved for the population as a whole; and how this can be done within the funds made available across health and social care.

Your question raises important points about future contract models. I don't believe that we can answer them now but they will become relevant as local thinking about the way organisations work formally as partners develops and we will certainly use them to inform our scrutiny.

We are clear, however, that any model which is developed in Brighton and Hove will need to be based upon providing health and care for the whole population and will include those who are "normally resident" as well as those who are registered with a GP."

25.3 Ms Sang asked a supplementary question:

"Risk and reward sharing is a key feature of the policy agenda for Accountable Care Organisations in the US and Integrated Care Systems in England. The Integrated Care Systems/Partnerships already rolled out by NHS England appear to adopt mainly a model of risk/reward or "gain/loss sharing" which offers a financial reward to limit health care.

What are HOSC's views on this culture of "managing" health-care demand for financial gain, and on its relation to the fundamental values of the NHS?"

25.4 The Chair thanked Ms Sang for her supplementary question. She agreed that any move to a model that rewarded health providers for under-treating patients would be troubling. Future scrutiny of the Long Term Plan will consider this issue.

25(B) Judith Anston

25.5 Ms Anston asked the following question:

"In B&H we have 1 GP for every 2,526 residents. This is one of the worst ratios in the country, the national average being 1 GP to 1,780 patients. (March 2019 figures, from FOI provided by B&H CCG)

Does the Long Term Plan address the need for more GPs in the city? Fewer surgeries is making it harder for some communities to access appointments, and access to less qualified staff is propping up provision: is the Long Term Plan undermining primary care?"

25.6 The Chair responded:

"Thank you for your question.

We are not yet in a position to say precisely what the Sussex Health & Care Plan, the local response to the NHS Long Term Plan, contains. The Sussex Plan should be published soon and the HOSC will seek to scrutinise it in some detail, starting at our March meeting.

I do share your concerns about city GP services, as I'm sure do other committee members, and the HOSC will look closely at what the Sussex Health & Care Plan has to say about developing city provision.

I recognise that there are valid concerns about access. GP practices are not evenly spread across the city, with a particular scarcity of provision in East Brighton and in Hangleton. This is a long-term issue, but has been exacerbated by recent Practice closures and mergers. Whilst it is important to recognise that larger practices can offer real benefits to patients as well as offering a sustainable business model, the question of access is an important one and something that the HOSC will focus on when it scrutinises plans for primary care in the city.

The HOSC will also want to focus on the use of a wider range of clinical professionals by GP practices. This can have real advantages, perhaps particularly in terms of patients being able to access really expert pharmaceutical advice or physiotherapy services from their GP practices. It also needs to be recognised that there is a national shortage of GPs and that there is no easy fix. However, it is crucial that the quality of care provided by GP practices is maintained and improved going forward, and the HOSC will certainly want assurance that any plans to diversify practice staff-mix have a robust evidence-base and are closely monitored to ensure that quality does not fall."

25.7 Ms Anston did not have a supplementary question, but did wish to note that most patients choose to register with their nearest GP as they value proximity of other issues. Any move to a model with fewer GP practices will therefore run counter to what patients want from GP services.

25(C) Valerie Mainstone

25.8 Ms Mainstone asked the following question:

"It is recognised that there has been a dramatic increase in the number of people who are struggling with their mental health: an increase due, at least in part, to the politics of austerity. It is worth recalling Aneurin Bevan's question "Why is it that in times of economic crisis the working class is made to bow its knee to the needs of capital?"

The funding of our Child Mental Services is the lowest in Western Europe. Up to 70%of those sleeping in our streets suffered a traumatic childhood, necessitating their being received into the care of the Local Authority.

The British Medical Association states that mental health workers are overworked, demoralised, and forced to deliver a compromised service. How will the Long Term Plan improve mental health services in Brighton, Hove and Portslade?"

25.9 The Chair responded:

"I do agree that mental health services are very important, and that they have not historically received all the attention they should. This is a national problem, but a particular issue locally: Brighton & Hove has worryingly high levels of people with mental health conditions, including young people. This is reflected in local suicide and self-harm rates.

The HOSC will certainly be looking to see what the local response to the NHS LTP is proposing to do to improve mental health services for city residents and to improve preventative services so that fewer people develop problems in the first place. We will expect to see really ambitious planning backed with a level of funding that recognises that high needs in the city.

We have also got a report on the recent Sussex-wide review of young people mental health services coming to this committee in March. Again, I would expect to see robust planning to improve services for children and young people, including better and timelier access into services."

25(D) Pat Kehoe

25.10 Ms Kehoe asked the following question:

"Is HOSC concerned that the recent raising of treatment thresholds and rationing of services is preparing the way to provide restricted budgets for Integrated Care Partnerships, irrespective of the care that is actually needed?"

25.11 The Chair responded:

"It is clear that there is considerable local concern about NHS plans to limit access to particular medical procedures, whether this is about ceasing to use particular treatments, limiting or delaying access to treatments, or raising the threshold for referral.

It does need to be recognized that there may be good reasons for these actions: as our understanding of medicine increases, we may find that some treatments are ineffective or even damaging or that they benefit only a proportion of patients. The NHS does need to regularly review the clinical basis for what it does and to act on the latest evidence.

The NHS Clinically Effective Commissioning programme, which is what I think the question is referring to, has been presented by NHS commissioners as just this type of review of the evidence base to ensure that all procedures are based on the best possible clinical evidence and not as an attempt to save money or to restrict spending in preparation for ICPs or any other change.

I do recognize that there are valid concerns about whether this type of initiative is clinically rather than financially led. I am confident that the evidence base for many of the Clinically Effective Commissioning changes was compelling, but I will ask CCG colleagues to provide the HOSC with some more information, set out in terms that are accessible for lay people, about some of the tranche 2 decisions that have caused local concern, specifically changes to the thresholds or treatment pathways for some orthopaedic surgery. This will be reported at a HOSC meeting later this year."

25.13 Ms Kehoe asked a supplementary question, enquiring when tranche 3 of the Clinically Effective Commissioning Programme would be published. The Chair responded that no date has as yet been communicated to the HOSC. Tranche 3 is on the work programme and will be scrutinised as soon as possible.

25(E) Liz Williamson

25.12 Ms Williamson asked the following question:

"In a recent meeting of the full council, concern was expressed about the democratic deficit which was illustrated by the CCG outvoting the elected members on the HWB on the fundamental issue of the Long Term Plan and Integrated Care. One Member went as far as to say it was simply a rubber stamping exercise.

This meeting followed a recent report on the Population Health Check in Brighton and Hove which revealed a lamentable 1.8% of the population were consulted. This statistic

is even more concerning since the population is expected to increase by a further 6% by 2026.

This democratic deficit experienced by both Council members and the local citizens of Brighton and Hove could be addressed in the form of a people's or citizen's commission on health and social care which would be under-pinned by the political will and support of the Council and which would provide Council Members with detailed information that would inform the decision making processes. Will the HOSC propose this more progressive and meaningful consultation drawing on the expertise of a wider group of people in Brighton and Hove with the knowledge and experience of health and social care?"

*Office of National Statistics estimate for population was 287,200 in 2016 with an estimated rise of 6% until 2026 reaching 304,300.

25.13 The Chair responded:

"I would be happy to discuss ways for the HOSC to engage with a people's commission on health and social care. For clarity though, I think it's important to note that the council has a very limited budget for engagement across many areas. I'm therefore not in a position to promise any kind of financial or administrative support.

I would be happy to arrange a meeting with you to further discuss your plans."

25.14 Ms Williamson asked that, if the HOSC is unable to establish a health commission, it should refer the matter to Full Council.

25(F) Linda Miller

25.15 Ms Miller asked the following question:

"Our local hospital is very short of staff. From the figures supplied by BSUH it appears we currently need 512 more nurses and 43 more consultants.

How does the CCG's Sussex Health and Care Plan address the shortfall of staff at our local hospital? Will the CCG's long term planning result in a sufficient number of nurses and doctors to serve our population? How can our local healthcare service improve if there isn't the staff to provide it?"

25.16 The Chair responded:

"Thank you for your question.

I share your concern at the very high number of medical and nursing vacancies at BSUH and would further note that vacancy levels at the Trust and at other local NHS trusts have been worryingly high for a long time. The local health and care system has long-standing issues with the recruitment and retention of staff, something that has been acknowledged by system leaders.

We will wait and see what impact Brexit has on the local NHS workforce situation, but nationally there has been a very significant fall in nursing applications from Europe following the Brexit decision.

I would also like to note the negative impact that the decision to end nursing bursaries has had. Political groups on the Council unanimously supported the partial reintroduction of bursaries last year.

We don't yet know the content of the Sussex Health & Care Plan, but I think you are quite right to identify workforce as a key element in any improvement planning. The HOSC will certainly seek assurances that the Plan addresses these longstanding issues of recruitment and retention as well as the allied performance issues that mean local people often have to wait much longer than they should for both emergency and planned healthcare, with Brighton & Hove residents currently having to wait longer than anyone else in England for planned operations. We know that the 3Ts development at the Royal Sussex Hospital will help with some of these performance issues, but the system clearly needs to find some effective workforce solutions also.

This is something that I hope NHS colleagues can begin addressing at today's meeting when we have a presentation on the NHS Long Term Plan – I have forwarded your question to them. It is also definitely an area we will address at the March HOSC meeting when we will begin scrutinising the definitive Sussex Health & Care Plan"

25.17 As a supplementary question Ms Miller asked what the HOSC would do if members were not satisfied with the workforce measures set out in the Sussex Health & Care Plan. The Chair assured her that this issue would be robustly pursued by the HOSC.

26 MEMBER INVOLVEMENT

26.1 There were no member questions.

27 HEALTHWATCH BRIGHTON & HOVE ANNUAL REPORT 2018-19

27.1 This item was introduced by David Liley, Chief Executive of Healthwatch Brighton & Hove (HW).

27.2 Mr Liley introduced the HW annual report. In the past year HW has:

- Sat on a number of bodies and committees
- Focused on service reviews and service 'audits'
- Begun measuring the impact of HW projects by looking at what percentage of HW recommendations are implemented (this is now around 75% from around 30% in HW's first year of operation)
- Continued to do good work despite reduced funding, in large part due to the dedication of volunteers. Coping with reduced funding is a challenge, but HW recognises that this

is a period of austerity and that many local HW organisations have seen deeper cuts to their budgets.

- Made a number of recommendations to health and care commissioners and providers, but would particularly point to its work in improving the environment in A&E and in care homes.

27.3 In response to a question from Cllr McNair on the challenges of recruiting volunteers, Mr Liley told members that volunteer numbers vary from year to year. HW is actively seeking to broaden its recruitment, working with city universities and voluntary organisations, advertising opportunities, and reaching out to GP practice Patient Participation Groups (PPGs).

27.4 In answer to a query on provider resistance to HW conducting 'enter & view' visits, Mr Liley noted that there has been surprisingly little resistance. HW does have statutory powers to enter & view but has never had to use these powers.

27.5 Mr Liley told the committee that the quality of food provided in hospital settings remains a concern: everyone in the system wants hospital food to improve, and BSUH does have a positive history of responding to HW recommendations, so it is hoped that more progress will be made.

27.6 In response to a question from Cllr Powell on the provision of lockers for in-patients at the Royal Sussex County Hospital, Mr Liley was unable to provide details of the relevant HW report at the meeting, but agreed to provide a written response.

27.7 In answer to questions from Cllr O'Quinn on HW's work on oral health in care homes, Mr Liley told members that HW has not yet re-visited homes so it is unclear to what degree its recommendations have been implemented. The Care Quality Commission (CQC) is aware of HW's work on this issue, and indeed uses it as an example of best practice, so this is something that the CQC may itself pick up during future inspections.

27.8 Mr Liley told the committee that many local HW organisations conduct multiple visits to care homes. However, this is not necessarily an effective use of resources; the HW Brighton & Hove approach is to share intelligence with the CQC and with commissioners and to undertake targeted interventions where specific concerns have been raised.

27.9 Mr Liley told members of the excellent work undertaken by Young Healthwatch, with support from the YMCA; highlighting a forthcoming report on sexual health services and the work that Young Healthwatch has done to make safeguarding information more accessible to young people.

27.10 In response to a question from Cllr Knight on mapping inequalities, Mr Liley told members that HW does undertake diversity and equalities impacts on all projects, but there is more that could be done here. However, HW has limited resources.

27.11 In answer to a question from Cllr Grimshaw on HW 'Listening Labs', Mr Liley told members that these tend to be held around specific issues and may be in advice centres, YMCA centres, or delivered on the street. Mr Liley agreed to send Cllr Grimshaw more information on this.

27.12 Cllr McNair noted the high user satisfaction with city GP services. Mr Liley remarked that the latest GP survey results show even stronger satisfaction despite significant issues, particularly in terms of access.

27.13 In response to a question from Cllr Powell about HW links with the community & voluntary sector (CVS), Mr Liley told members that HW was very well-linked with the local CVS and also with HW organisations across Sussex. Mr Liley also suggested that the HOSC might wish to look at how effective BHCC and NHS engagement is with 'hard to reach' communities. Cllr Powell agreed, noting that it might also be useful to look at the accessibility of some hospital settings.

27.14 In answer to a query from Colin Vincent as to whether HW had ever escalated local issues to Healthwatch England or to the Secretary of State for Health, Mr Liley confirmed that some issues had been escalated: e.g. Sussex Patient Transport Services and Personal Independence Payments.

27.15 The Chair asked which issues HW would advise the HOSC to scrutinise, and Mr Liley suggested the following:

- GP practice sustainability and the sustainability of the Primary Care Network (PCN) model;
- Acute healthcare performance against national targets
- Complaints & Advocacy (e.g. how to make the system less complex)
- Unregulated (i.e. not regulated by the CQC) social care services: e.g. high support housing;
- Equalities and engagement
- End of life care.

28 THE SUSSEX HEALTH & CARE PLAN - LOCAL RESPONSE TO THE NHS LONG TERM PLAN

28.1 This item was introduced by Ashley Scarff, CCG Director of Partnerships and Commissioning, and by Lola Banjoko, CCG Managing Director (South). Ms Banjoko noted that the local response to the NHS Long Term Plan (LTP), the Sussex Health & Care Plan (SHCP), is a system response, involving all local NHS Trusts and commissioners, but also local authorities and the community & voluntary sector (CVS).

28.2 The key objectives of the SHCP are:

- To reduce health inequalities.
- To improve outcomes.
- To be person-centred.
- To accurately reflect local need – the local plan is informed by the Joint Strategic Needs Assessment and the Brighton & Hove Joint Health & Wellbeing Strategy (JHWS). The main areas of SCHP focus, cancer, multiple long term conditions, children & young people, and mental health, are also the main issues facing Brighton & Hove as identified by the JHWS.
- Better utilising local assets, including CVS capacity, via social prescribing.
- More joined-up working (e.g. the local homeless care pathway).

- Better use of workforce (e.g. reducing duplicated visits to care homes)
- Using data and digital to underpin improvement (e.g. South East Coast Ambulance Trust should be able to access people's care plans/end of life plans when responding to emergency calls.
- Delivering a shared vision with partners working positively together.
- To deliver as much care as possible via 'neighbourhoods', with 30-50,000 populations. These represent the smallest unit that can realistically sustain a range of community and primary health services, care services and services linked to the wider determinants of health such as housing. Neighbourhoods represent the fundamental planning block for both the SHCP and the JHWS.
- To deliver primary health services via a Primary Care Network (PCN) for each Neighbourhood. PCNs will help support GP Practice resilience, a key issue given intense workforce pressures currently being experienced. They will also collectively provide services such as physiotherapy and social prescribing, advancing the LTP's preventative agenda and transferring activity away from the acute sector.
- To develop the Sussex Health & Care Partnership on a Sussex-wide footprint, reflecting the fact that all local NHS Trusts work across local authority areas. The Sussex Health & Care Partnership will bring commissioners and providers of health and care together to plan services, spread good practice and work together to improve delivery.

28.3 Mr Scarff noted that the LTP introduces no new organisations or entities. This is about existing organisations working together in different ways.

28.4 In response to a question from Cllr Hugh-Jones, Ms Banjoko confirmed that all city GP practices have chosen to join a PCN. The LTP does not mandate the consolidation of GP practices, although practices within a PCN might opt for consolidation if it increased their sustainability.

28.5 In answer to a query from Cllr Hugh-Jones on data integration, Ms Banjoko acknowledged that the NHS had a patchy history with major IT projects. However, lessons have been learnt from past experiences and the technology to enable data sharing has improved in recent years. The initial focus will be on the integration of summary acre records.

28.6 In response to a question from Cllr Hugh-Jones on whether plans to ensure that any LTP changes requiring additional patient journeys would be supported by sustainable and affordable travel options, Ms Banjoko responded that this would be explored in individual service change planning. It should however be noted that the 3Ts development at the Royal Sussex will enable the repatriation of some specialist services to the city, reducing patient and family journeys.

28.7 In answer to a query from Cllr Hugh-Jones about LTP engagement, Mr Scarff informed members that previous engagement exercises such as "Our health, our care, our future" had informed the local response to the LTP. More engagement is planned, and there will be specific engagement and consultation relating to implementation of any service changes.

28.8 In response to a question from Cllr McNair on whether the LTP would entail the redistribution of primary care assets across the city, Ms Banjoko told the committee that this would be up to GP practices. Mr Scarff added that PCNs may seek to differentiate

between patients who require generic GP services and those who need continuity of care from a named GP in order to ensure that finite resources are deployed as effectively as possible.

28.9 In response to a question on whether the ability to book Urgent Treatment Centre (UTC) appointments was yet in place, Ms Banjoko promised to provide a written response.

28.10 In answer to a query from Cllr Hills on membership of the Integrated Care System (ICS) Executive Group, Mr Scarff confirmed that the Chief Officers of NHS providers and commissioners would be invited, as would local authority Directors of Adult Social Care (DASS). There would also be support from the medical and clinical directors of the member organisations. Mr Scarff stressed that the ICS would have no delegated authority to make decisions, with accountability retained by member organisations. There is no elected member representation on the ICS, with Health & Wellbeing Boards expected to be the key vehicle for democratic accountability.

28.11 Cllr Knight commented that she was unconvinced by the term 'neighbourhoods': areas of 30-50,000 people are catchment areas rather than homogenous communities. She also noted that the language used to explain some of this information was unclear. Mr Scarff noted that 'neighbourhood' is a term being used by the NHS nationally. Whilst accepting Cllr Knight's point, he stressed that 'neighbourhoods' present a more granular scale for commissioning than is typically the case; it would not be possible to deliver sustainable service provision at a smaller scale.

28.12 Cllr Powell asked questions about the steps taken or planned to ensure that there was engagement with a wide range of city communities representing people with protected characteristics. Ms Banjoko assured members that equalities issues were being taken very seriously. Engagement materials will be made available in (easy to read) print, braille and sign forms; engagement events will be accessible; there will be dedicated events for certain groups (e.g. people with a learning disability); the CCG will work closely with community & voluntary sector groups when planning engagement; the CCG will work with public health to ensure they have accurate data on people with protected characteristics; the CCG will actively use its staff networks to support engagement with specific groups (e.g. involving BAME staff in engagement with BAME communities).

28.13 In response to a question from Fran McCabe on engagement with the private sector, Ms Banjoko told members that the local private sector is essentially domiciliary care and residential care: there are no significant local private healthcare providers. There will be engagement at a neighbourhood level: e.g. linking hospital gerontologists to local residential care homes in order to reduce unnecessary hospital admissions. Mr Scarff added that it was more challenging to engage with domiciliary care providers, but this is something the system is committed to doing. There is also a commitment to engage effectively with carers, including support via the Better Care Fund.

28.14

29 OSC DRAFT WORK PLAN/SCRUTINY UPDATE

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Public Questions: HOSC 18 March 2020

1 Clare Jones

Question for HOSC concerning the Substance Misuse service – new contract April 1st 2020:

Despite the ringing endorsement of the current substance misuse service provider (Pavillions) at the January 2019 Health and Wellbeing board, they have failed to secure the new contract that will come into force in April 2020.

I am aware that the January 2019 Health and Wellbeing board gave delegated authority to the Executive Director of Health and Adult Social care for both the procurement process and the awarding of the contract. This means, of course, that no details at all of the new contract, the supposed failings of the current provider or the examination of the track record of the new provider, CGL, has been subject to democratic scrutiny or oversight. My question is – what overview and scrutiny has the HOSC done of this service and the new contract, especially in the light of staff and service cuts. (For instance the current services offered at 9 the Drive are to close).

2 Pat Kehoe

Regarding the HOSC agenda item 36, **SUSSEX HEALTH & CARE PLAN: LOCAL RESPONSE TO THE NHS LONG TERM PLAN.** The HOSC have been asked to 'note' the 'plans' for both Brighton & Hove City and Sussex, which, with the Sussex Care and Health Partnership being on the ICS Accelerator Programme, will come into being from April, 2020. At the end of the item it says that no 'direct' public engagement has taken place and that the financial implications are 'not relevant'. If these 'plans' are starting in April 2020,
a) what scrutiny/investigations/proof/evidence have been undertaken/reviewed by the Council to substantiate that the 'plans' will improve health and care outcomes for the residents of Brighton & Hove City?
b) when does the Council consult with its residents regarding this fundamental change to the delivery of Primary Care? Is this not a Substantial Variation in Service?
c) when does the Council sign its agreement to being a partner in the 'plans'? If the Council is committing to these 'plans' there must be a formal signing of an agreement to action them.
d) what are the financial, manpower, estate implications for the Council of being a partner? Surely, for budgeting purposes the Council must know this information.

3 Madeleine Dickens

By the CCG's own admission in the report to their Primary Care Commissioning meeting of 10th March some Primary Care Networks require substantial work,

entailing "a radical workforce transformation and a complete re-design of primary care clinical pathways".
The need for this is made even more urgent by other admissions in the report - namely ***The current consultation document demonstrated that PCNs would increase workloads and put practices at financial risk so it required a fundamental rethink around the original premise of what a PCN would be for and how it would work.***
This is a clear admission of the need for the HOSC and Brighton and Hove Council to raise a Substantial Variation in Service order in relation to the changes in NHS services being proposed by the CCG. It also highlights the need to subject the as yet unworked out arrangements to the most meticulous scrutiny and public consultation before reaching any binding decision to approve any Council cooperation in these arrangements whatsoever. No less than the future health of our city is at stake.

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 33 Brighton & Hove City Council

Subject:		**Adult Social Care Quality Monitoring Arrangements**		
Date of Meeting:		**18 March 2020**		
Report of:		**Executive Director, Health & Adult Social Care**		
Contact Officer:	**Name:**	**Michelle Jenkins, Marnie Naylor, Andrew Witham**	**Tel:**	**01273 296271/6033/1498**
	Email:	**Michelle.jenkins@brighton-hove.gov.uk; marnie.naylor@brighton-hove.gov.uk; andrew.witham@brighton-hove.hov.uk**		
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

Glossary

- **Shared lives:** Shared Lives is a way to support adults, and young people over the age of 16, who are unable to live independently. Shared Lives scheme place the adult or young person with someone who offers accommodation, care and support in their own home. Support can be provided full time, or as short breaks and respite or day activities.

- **Residential (Care) Homes (non-nursing & nursing):** a Residential Care Home is a place where personal care and accommodation are provided together. Care Homes provide live-in accommodation; with 24 hour-a-day supervised staffing for residents, who may need extra help and support with their personal care. Residential care homes provide dining facilities, and often include a social programme and activities (e.g. music/yoga classes/arts therapy/outings) for their residents. A Nursing Home (care home that provides nursing care) also provides 24 hour care and support, as a care home (non-nursing), but with the added nursing care and assistance for residents who require input from and supervision by a registered nurse who is in situ to devise and monitor care plans, provide and administer medical treatment. Both the care that people receive and the premises are regulated by the Care Quality Commission.

- **Homecare:** (also known as domiciliary care) is a range of services put in place to support an individual in their own home. Services may involve routine household tasks within or outside the home; personal care and other associated domestic services necessary to maintain an individual in an acceptable level of health, hygiene, dignity, safety and ease in their home.

- **Supported Accommodation:** supported living services provide suitable accommodation with additional personal care. Unlike Care Homes this care will be provided at set times and may not be available 24 hour per day.

- **Care Quality Commission (CQC):** the CQC is the independent regulator of

health and social care in England.

- **Clinical Commissioning Group (CCG):** CCGs are responsible for implementing the commissioning roles as set out in the Health and Social Care Act 2012. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

- **Health watch:** Healthwatch England was established as an effective, independent consumer champion for health and social care. It also provides a leadership and support role for the local Healthwatch network. Nationally and locally, Healthwatch have the power to make sure that those in charge of health and social care services hear people's voices. They encourage health and social care services to involve people in decisions that affect them.

- **Dynamic Purchasing System:** a Dynamic Purchasing System (DPS) is a completely electronic system used by a Contracting Authority (buyer) to purchase commonly used goods, works or services. Unlike a traditional framework, suppliers can apply to join at any time.

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report has been produced following a request by the HOSC Chair to map out the current roles/responsibilities that the council's Quality Monitoring Team (QMT) covers in reference to quality monitoring and supporting providers in the city of Brighton & Hove.

1.2 The HOSC Chair requested an update following the recent CQC report for Priory Rookery Hove which received an overall 'Inadequate' CQC rating in all areas, dated 17 January 2020.

2. RECOMMENDATIONS:

2.1 That members note the contents of this report.

3. CONTEXT/ BACKGROUND INFORMATION

Background

3.1 Brighton and Hove City Council (BHCC), Clinical Commissioning Group (CCG), and the Care Quality Commission (CQC) work in partnership to gather intelligence in order to prioritise intervention following any significant concerns about services provided to vulnerable adults living in the city. Brighton & Hove currently has a high level of providers in the city with a CQC rating of overall 'Good' *See **Appendix 8:** Summary of latest published new approach ratings of active Social Care Organisation locations in Brighton and Hove.*

3.2 Significant concerns may arise from CQC inspections resulting in 'Requires Improvement' or 'Inadequate' for key areas inspected: e.g. are services safe, well-led, caring, responsive and effective? There is a joint emphasis to help providers to improve by offering support and advice through the quality assurance roles that the council's Quality Monitoring Team (QMT) and the CCG provide. This could include clinical advice and improvement to support Care Homes: e.g. links to various services: 'SALT' (speech and language team), falls prevention, end of life care, support regarding medication issues, bespoke training for autism awareness etc.

3.3 Care provision is a dynamic market where providers face constant challenges. From time to time, all providers may get into difficulties for a variety of reasons. Over the past few years a significant challenge has been an increase in problems of recruitment and retention of staff in the care sector, a major issue leading to a lack of qualified and well trained health and care workers. The city has also seen a high turnover of 'Registered Managers', (this is representative across the country) which can result in a service's overall CQC rating changing from an overall 'Good' rating to 'Requires Improvement'. Having the right person leading a service (care home, home care etc.) along with well trained and motivated staff can also see CQC ratings go from an overall 'Requires Improvement' rating to overall 'Good. On rare occasions a provider regulated by the CQC may receive an overall rating 'Inadequate' or 'Outstanding'.

3.4 The role of the council's Quality Monitoring Team is to build positive relationships with providers across the city through a planned review schedule (minimum of a desk top review every two years), working with other key professionals/organisations and on-going support as and when required. The QMT can often pick up on issues of concern before they become much bigger problems for a provider. This proactive approach undertaken by the council has supported many difficult situations over the past four years since the team commenced, and has prevented several business failures.

3.5 During 2018, a large national organisation that provides nursing care in the city (CQC rated 'Inadequate'), had twelve months input from the QMT including others to support them through a difficult period, the home has since received a CQC rating of overall 'Good', and now supports adult social care by providing supplementary assessment beds for hospital discharges. A further two nursing homes receiving a CQC rating of overall 'Inadequate' are currently rated overall 'Good', following intensive support from the QMT and CCG quality team.

3.6 It is important to note that there is a limited supply of care providers in the city, with demand often out-stripping what is available; closure is not necessarily a positive option to consider. Care providers exiting the market is always a last resort as an outcome.

Role of the CQC

3.6 The role of the Care Quality Commission (CQC) as an independent regulator is to register health and adult social care service providers in England and to inspect whether or not standards are being met. The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and publish what they find, including performance ratings to help people

choose care. Their core role is to inspect whether or not 'key' standards are being met.

3.7 Unlike the QMT, the CQC can force improvement through one of the following civil enforcement powers:

- Imposing, varying or removing conditions of registration;
- Suspending registration;
- Cancelling registration; &
- Adopting urgent procedures

The CQC can bring prosecutions for breaching key regulations under their powers as the independent regulator.

3.8 From 2019, CQC now inspects providers rated as overall 'Good' only every 30 months, whereas QMT provides on-going and ad-hoc support to providers as and when required. A service rated overall 'Outstanding' has up to 5 years before its next inspection. A service with a rating of overall 'Inadequate' will receive a follow up inspection within 6 months, and overall 'Requires Improvement' 12 months. Inspections can be moved dependent on any significant issues of concern which are often provided as evidence by QMT.

3.9 **Standards of care.** CQC set out what good and outstanding care looks like and make sure services meet fundamental standards below which care must never fall. See **Appendix 1**: CQC fundamental standards explanation.

3.10 **What happens if care is poor**?

Where CQC find poor care, they will use their powers and take necessary actions, these include:

- Using *requirement notices* or *warning notices* to set out what improvements the care provider must make and by when.
- Making changes to a care provider's registration to limit what they may do, for example by imposing conditions for a given time.
- Placing a provider in *special measures*, where they closely supervise the quality of care while working with other organisations to help them improve within set timescales.
- Hold the care provider to account for their failings by:
    - issuing simple cautions
    - issuing fines
    - prosecuting cases where people are harmed or placed in danger of harm.

Everybody has the right to receive safe, high-quality care. If CQC find that care has fallen short of this, they can use their powers to take action against those responsible.

The CQC uses their powers and takes action to:

- Protect vulnerable people using services from harm and make sure individuals receive care that meets the standards individuals have a right to expect
- Make sure services improve if the standard of care they provide has fallen below acceptable levels.
- Hold care providers and managers to account for failures in how care is provided.

What action CQC take depends on how the problems they've identified affect the people who use the service and how serious they are.

3.11 *CQC inspections to Residential Adult Social Care services:* CQC inspections will usually be unannounced. In a few instances, where there are very good reasons, CQC may let the provider know they are coming. For example, they may contact small homes to check that people are home before setting off to inspect.

3.12 *CQC inspection to Community Adult Social Care services:* CQC inspections of domiciliary care agencies and Shared Lives schemes will usually be announced 48 hours in advance. This is so CQC can be sure the manager or a senior person in charge is available on the day they plan to visit.

CQC may also give 48 hours' notice to supported living schemes and extra care housing, but this will vary depending on the way the service is organised – in particular, in relation to the location of the registered manager and people using the service.

3.13 **Types of inspection:**

CQC carry out regular checks on health and social care services. CQC call these comprehensive inspections and use them to make sure services are providing care that's safe, caring, effective, responsive to people's needs and well-led.

CQC also carry out focused inspections. These are smaller in scale than comprehensive inspections, although they follow a similar process.

CQC carry out focused inspections for two reasons:

- To look at something they're concerned about, which might have been raised during a comprehensive inspection or through CQC monitoring work.
- If there is a change in a care provider's circumstances. This might mean they've been involved in a takeover, a merger or an acquisition.

A focused inspection doesn't always look at all five of CQC's key questions (see below 3.15). The size of the team and who's involved depend on what the inspection is looking at.

3.14 **Gathering evidence:**

The CQC inspection team uses the key lines of enquiry (3.15) and information from the planning stage to structure their visit and focus on areas of concern or areas where the service is performing particularly well. The team collects evidence against the key lines of enquiry by:

- Gathering the views of people who use services. This includes:
    - Speaking to people individually and in groups.
    - Using comment cards placed in GP surgeries or busy areas in hospitals.
    - Staffing pop-up engagement stalls before NHS acute hospital trust inspections.
    - Using information gathered from complaints and concerns from people who use services.

- Gathering information from staff.
- Other inspection methods include:
    - Observing care.
    - Looking at individual care pathways.
    - Reviewing records.
    - Inspecting the places where people are cared for.
    - Looking at documents and policies.

There are five questions CQC ask of all care services. They're at the heart of the way CQC regulate and they help to make sure CQC inspectors focus on the things that matter to people.

3.15 **Key Lines of Enquiry**

CQC ask the same five key questions of all the services they inspect, these are called Key Lines of Enquiry (KLOES).

Are they safe?
Safe: individuals are protected from abuse and avoidable harm.

Are they effective?
Effective: individual care, treatment and support achieve good outcomes, help individuals to maintain quality of life and is based on the best available evidence.

Are they caring?
Caring: staff involves and treats individuals with compassion, kindness, dignity and respect.

Are they responsive to people's needs?
Responsive: services are organised so that they meet individual's needs.

Are they well-led?
Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Role of the Quality Monitoring Team (QMT)

3.16 **Background:**
The team is approx. 4.1 FT/E staff working Monday to Friday, made up of 6 team members (includes one manager).
The team operates a duty system throughout the week (M-F) to ensure any quality issues relating to Health & Adult Social Care (HASC) provider services that the council has a contract with are picked up by any team member and dealt with swiftly. See **Appendix 2**: Quality Monitoring-Quality Assurance Framework (please refer to this document for a full breakdown of the role and responsibilities of QMT including frequently asked questions); and **Appendix 3**: Quality Monitoring Team pathway.

3.17 **Role of Quality Monitoring Team:**

The QMT is responsible for supporting all adult social care framework contracted services (including in house provider services) across the city. The team's role is to monitor that good quality care is provided in services to keep people safe. The team gather information about providers through various ways: e.g. complaints, safeguarding enquiries, information from social care staff (safeguarding leads, social workers, and whistle blowers etc.). QMT also works closely with other professionals including Clinical Commissioning Group (CCG) and Care Quality Commission (CQC) colleagues, to share information to build up a picture of 'services of concern'. QMT and CCG developed a joint template (January 2018) to be used during all Quality Monitoring assurance audits. The audit follows similar principles to CQC focusing on the five key lines of enquiry. Information gathered helps the QMT to look at any themes emerging: e.g. poor medication administration, multiple missed calls, low staffing levels, out of date training, poor systems in place etc.

The QMT maps out all the information received by RAG rating it (Red/Amber/Green); this will include feedback on 'key lines of enquiries' (KLOEs) from any CQC inspections. All of the information gathered is then transferred to individual files for each provider and also transferred to a 'Service Improvement' document which is discussed during monthly Service Improvement Panel meetings (SIP), attended by a broad cohort of staff including representation from CCG, Continuing Health Care (CHC), social workers, and commissioners.

Outcomes from monthly SIP meetings may include actions for the QMT to carry out the following:

- A focused quality monitoring assurance audit visit to a provider service of concern: e.g. a joint visit with CCG colleagues to look at medication procedures, medication charts, and recording etc.

- A full Quality Monitoring assurance audit of a service may be requested which follows the principles of CQC KLOEs: is the service: Safe, Effective, Well-Led, Responsive and Caring.

  Each member of the team has a lead area to cover, and supports a second service area. A full audit will be carried out over a whole day and cover most arears of the service for example:

  - Individual care plans/risk assessments, medication charts etc.
  - Staff files (including recruitment/induction, supervision and training)
  - Policies & procedures
  - Health & safety
  - Observations during the visit (including talking to staff, people using the service and visitors)
  - Tour of the premises

  (See **Appendix 4**: Service Improvement Panel Terms of Reference)

  The information gathered about service providers is also shared during joint quality meetings hosted by CCG and CQC colleagues. Summary information is also presented in a quarterly report produced about quality monitoring activity for the Care Governance Board, chaired by the HASC Assistant Director Resources,

Safeguarding & Performance *(*see **Appendix 5**: Care Governance Board Terms of Reference).

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The QMT also arrange planned visits as part of their role; each has a lead area to cover. The team has a set a target outcome to achieve at least a desk top review (DTR) for each service under its remit within a two year period. This target was met for period 2018/19 *(see table one below).*

At the time of writing this report (Feb 20) there are currently five providers in the city receiving additional support due to being risk rated Amber or Red on the Service Improvement main table of concerns. The highest number of providers recorded as receiving support and close monitoring at any one time was 17.

3.18 **Areas covered by QMT:**

The QMT carries out both *planned* and some *unplanned* audit visits similar to the CQC; currently QMT covers the following services that are contracted and commissioned by BHCC council:

- Nursing Homes
- Residential Care Homes (non-nursing), including Learning Disability care homes
- Home Care (main framework providers)
- Supported Living (Learning Disability)
- Acquired Brain Injury (ABI) and Physical Disability Services (that fall under supported living or care homes)

In addition to the contracted providers the QMT also quality monitors all In-House services (except for the High Support Accommodation services, which are not CQC registered). Currently there are 13 in-house services being monitored included in the figures (see table one below). High Support Accommodation services are monitored by the Rough Sleeping and Homeless Support Services Team which commissions them.

table one: current number of services that are commissioned / contracted being quality assurance monitored by QMT February 2020

Service Type	Total Number
Care Home: Independent sector- Older People (without nursing)	19
Care Home: Independent sector Learning Disability	20
Care Home: Independent sector Older People Mental Health	6
Care Home: Independent sector Adults Mental Health	5
Care Home: Independent Sector Sensory Loss	2
Care Home: Independent sector Acquired Brain Injury	1
Care Home: Council Learning Disability	5
Care Home: Council Adults	3
Total Care Homes	61
Nursing Homes: Independent sector	26
Shared Lives: Council	1
Home Care: Independent sector on Framework Contract (including back up providers)	10
Home Care: Council (Independence At Home)	1
Supported Living : Independent sector	41

Supported Living: Council	3
Total	143
*High Support Accommodation : Council	2
*High Support Accommodation: Independent Sector	2
Total	147

**The Rough Sleeping and Homeless Support Services Team monitors the contract and quality of all High Support Accommodation*
The above figures do not include providers that are not commissioned and audited by QMT or services that are commissioned using the 'dynamic purchasing system' DPS only

3.19 **Registered Services not commissioned/covered by BHCC that are registered under CQC:**
The QMT also collates information for all HASC provider services that are not commissioned/ do not have a contract with BHCC. QMT keeps a record of any safeguarding or other significant issues passed to the team onto the SIP database. The QMT also hold individual files on each provider, which are updated as required. Any safeguarding issues always sit with the 'host' local authority regardless of any placements being made by the host authority.

Any further involvement by QMT must be acceptable to the provider e.g. QMT to carry out a full quality monitoring assurance audit. This is particularly valuable where there may be multiple placements with a provider where no contract exists with the council and therefore quality can still be monitored to some degree.

This approach by the council is over and above what some other local authorities may provide, but this vigorous and continued support has been proven to obtain positive results for providers, and subsequently for vulnerable people receiving care.

3.20 **Areas not covered by Quality Monitoring Team (QMT):**
The QMT does not carry out quality monitoring audits (as per day to day work) for a number of services these include:

- Hostel services: Rough Sleeping and Homeless Support Services Team monitors the contract and quality of all Hostel services.
- DPS services (commissioned under the dynamic purchasing system) DPS providers do not fall under the two-yearly desktop review process carried out by the QMT. Any quality issues identified for a DPS provider will be discussed during the monthly SIP process and escalated as required, which may include as an action a quality monitoring audit focused visit.
- Non Commissioned Services (not on framework contract)
- Services commissioned individually by CCG or Continuing Health Care (CHC)
- Day Services (Day Centers): these are not CQC registered
- Children's services

The QMT is unable to support any individual cases: e.g. supporting Mrs. X and her family following a complaint raised about a care home placement. Any individual cases requiring further investigation would sit with BHCC Assessment Team (social workers) to lead on. Information regarding any complaints, or other significant information etc. is used to build on portfolios held about each contracted provider overall. This information will help the QMT to look at any themes emerging: e.g. poor medication administration, low staffing levels, poor systems in place etc.

3.21 **Professionals Meetings:**

Professionals meetings are held if serious patterns emerge about a service provider. These could include: a serious/major incident has occurred resulting in hospitalisation/death; CQC have rated a service as overall inadequate or various information has been received about a service provider from different/same sources over a period of several weeks/months (themes) that raise a significant concern. SIP meetings are used to determine when a 'professionals' meeting may be required. The meetings aim to support the provider and to develop comprehensive action plans to improve the service and safety of those using it. Subsequently this could lead to a suspension or even a contractual exit plan once all other avenues have been exhausted fully over an agreed period of time.

3.22 **Suspending a Provider:**

There are a limited number of providers in the city; therefore the council has opted for a supportive process when a provider is struggling. On very rare occasions a service may need to be suspended; if a service is suspended this means that no new BHCC funded placements can be made during the suspension period. The decision to suspend any new placements in any service will always have the safety and welfare of people who use services at its heart and this will be paramount in all decision making. The decision to suspend is delegated to the Head of Commissioning (Health & Adult Social Care), based on advice from the Service Improvement Panel. In their absence the Director of Adult Social Services will take the decision.

Support during a Suspension: Whilst a service is suspended the provider will not be able to take any new placements and referrals until such a time as significant improvement is evident. The QMT will work with the provider (to include CCG quality monitoring colleagues and commissioners as required) to provide appropriate support. This may include regular focused visits to check against progress on the actions agreed during professionals meetings.

The council's QMT and CCG quality team may also involve other colleagues to support the home: e.g. Dementia Care Home in-Reach Team (CHiRT), Speech and Language Team (SALT), Learning & Development etc.

The QMT will regularly feedback on progress to commissioners and the CQC. By providing proactive support, often on a longer term basis, the QMT has kept providers remaining in the city that may otherwise have exited the market.

During the period January 2018- current (Feb 2020), the council suspended a total of six contracted provider services. Suspensions are made on an individual basis, however if a service is rated by the CQC as overall 'Inadequate' the

service will automatically be suspended by the council; please see table two below:

Table two: *number of providers suspended since January 2018 to February 2020*

Category of Provider	CQC Rating overall	Currently Suspended	Comments
Nursing Home	Inadequate	No	Currently overall **'Good'** CQC rating
Nursing Home	Inadequate	No	Currently overall **'Good'** CQC rating
Nursing Home	Inadequate	Yes	Currently overall 'Inadequate' CQC rating
Care Home (non-nursing)	Inadequate	Yes	Currently overall 'Inadequate' CQC rating. This provider was suspended originally whilst CQC rated overall 'Requires Improvement' due to significant safeguarding concerns
Home Care	Requires Improvement	No	No longer CQC registered
Home Care	Inadequate	No	No longer contracted with the council

For further information about suspensions, please refer to: Health & Adult Social Care Suspension policy and process December 2018 (See **Appendix 6**: BHCC Suspension Policy)

Additional Support to Providers

3.23 **Health & Safety (Fire Safety Compliance) support:**
The Council is responsible for ensuring that a good quality standard of care and safety is provided in Nursing/Care Homes, Supported Living and Community support provided by Home Care services across the City. The QMT has an excellent relationship with the Health & Safety Business Partners to ensure H&S and Fire compliance is met, making recommendations where shortfalls are identified. This joined-up flexible approach allows vital intelligence to be shared to enable any risks identified to be addressed in a timely manner by offering advice, guidance, and support to ensure people receiving services are kept safe. As part of the working arrangement H&S business partners currently carry out up to six full day H&S audits to care homes each quarter; these are determined/requested by QMT.

3.24 **Care Home in-reach Team (CHIRT):**
The team is made up of Occupational Therapists working for Sussex Partnership Foundation Trust.

The Brighton and Hove Dementia Care Home in Reach team (CHiRT) work in partnership with care homes, the care staff and residents' families to promote quality of life and meaningful occupation for the residents with a dementia. As part of a bespoke action plan with each home CHiRT develop evidence-based psycho-social interventions.
QMT meets regularly with CHiRT to share information about providers and also receives bespoke training sessions on a regular basis to support quality assurance visits to homes that provide dementia care.

3.25 **Forums:**
BHCC and CCG hold three joint Care Home forums per year and forward plan agenda items generated by ideas from providers. The working group consists of care home managers who meet on a regular basis to support the forum meetings and ensure topics are relevant, wanted and engaging. Each forum meeting has a host of guest speakers, stall holders, and opportunities for managers to network. Since February 2018 CQC has attended each forum to provide managers an opportunity to ask any CQC-specific questions during the event.
Three yearly forums are also held for Home Care and Learning Disability providers, led by commissioners.
Feedback from these forums is always very positive, and there are often a high number of providers wishing to share 'good news' stories.

3.26 **Healthwatch Lay Assessors volunteer visits:**
Healthwatch Brighton & Hove is a registered Community Interest Company. The role of Healthwatch Brighton & Hove is a health and social care watchdog run by and for local people. It is independent of the NHS and BHCC.

Healthwatch Lay Assessors interview people receiving home care from local providers, speaking to residents plus their families about their experience and the quality of service they receive. Lay Assessors feedback that information to Healthwatch which collates and shares written reports with Brighton & Hove City Council to ensure the service providers maintain a high quality of care.

BHCC Performance & Business Improvement Team, with support from QMT, meets with Healthwatch on a regular basis to inform the programme of work for the Lay Assessor interviews. Outcomes of these reports are shared with the relevant provider and the QMT. Providers have the 'Right to Respond' feeding back on any changes or updates that have taken place during and after the time of the report.

This information helps the QMT to determine whether a broader focused quality audit is required: e.g. monitoring of staff training records or focusing on medication recording etc.

3.27 **Workforce Development:**
The Workforce Development team at Brighton & Hove City Council provides and delivers a comprehensive funded training programme to both council employed care and assessment services, and externally commissioned care providers, community voluntary sector providers, Personal Assistants, informal carers and partners across the city. The programme offers over 7,000 training places, online

learning, and access to relevant conferences (Safeguarding & Adult Social Care Showcase) and other resources to support the wider health and social care sector to deliver high quality cost effective services.

The team also provides development interventions, advice and guidance for service providers on regulation and on any quality issues identified. As well as responding to developments, such as changes in social care law, the team has representation at a number of strategic forums (Care Governance Board, Skills for Care, SE ADASS [South East Association of Directors of Adult Social Care] Workforce Group, Clinical Education Provider Networks, Health Integration Group) and other local provider forums that help to develop policy and the wider workforce delivering adult social care across the city.

3.28 **Nursing Homes Professionals Meetings:**
CCG facilitates quarterly multidisciplinary meetings made up of clinicians, CQC representatives and QMT to discuss any relevant quality and safety issues relating predominantly, although not exclusively, to Nursing Homes. Actions from these meetings may include joint visits to provide additional support to homes for example: Speech and Language Therapists (SALT team) can provide bespoke training for individuals relating to swallowing issues; Registered General Nurses (RGNs) can provide support regarding wound care, Martletts can provide 'end of life training' etc.

Feedback from Providers

3.29 From January 2019, the QMT started to request feedback from providers by sending out a post visit survey. Feedback will help determine what is helpful about the support provided, and identify areas for improvement (see **Appendix 7**: Post Survey Report 2019).

Quality Monitoring Neighbouring Authorities

3.30 Neighboring local authorities have different ways in which they quality monitor provider services, East Sussex County Council (ESCC) has a Market Shaping Team (MST). Following the success of ESCC quality monitoring team supporting over 20 providers in the past that had an overall CQC rating of 'Inadequate', a decision was made by ESCC that the MST will now only support those providers that are struggling or receive future poor CQC ratings. This way of monitoring providers could potentially see an increase in CQC ratings of 'Requires Improvement' and 'Inadequate' due to little or no input to services that may otherwise do well with more regular monitoring, input and advice.

West Sussex County Council (WSCC) does not have a separate quality monitoring team function and rely on the regulator role of CQC. In the past 18+ months significant concerns about a major care provider in WSCC, has seen 11 out of 19 services being provided by one organisation receiving a CQC rating of overall 'Inadequate' with the remaining eight rated as 'Requires Improvement'. Issues of concern may have been highlighted much sooner and with less of an impact if WSCC had adopted a different monitoring approach.

The robust systems put into place by BHCC QMT have enabled providers to maintain high numbers of overall 'Good' & 'Outstanding' CQC ratings in the city.

(See **Appendix 8:** CQC data January 2020.Please note CQC ratings may go up as well as down depending on multiple factors).

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not applicable to this report for information rather than decision.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None undertaken directly in relation to this report. Members should note the involvement of Healthwatch Brighton & Hove in the quality monitoring process (see 3.27 above).

6. CONCLUSION

6.1 Members are asked to note the local process for monitoring adult social care quality, supporting providers, and intervening where necessary.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 There are no financial implications as a direct result of the recommendations of this report. However, any measures recommended by the Quality Monitoring Team to support providers and similarly, any actions taken by regulatory bodies, may have an impact on the broader costs of care funded by the Council.

Finance Officer Consulted: Name David Ellis Date: 20/02/20

Legal Implications:

7.2 Section 5 Care Act 2014 places a duty on Local Authorities to promote the efficient and effective operation of a market in services for meeting care and support needs in its area and in particular to have regard to the importance of fostering continuous improvement in the quality of such services and the efficiency and effectiveness with which such services are provided.

Lawyer Consulted: Name Sandra O'brien Date: 26/02/2020

Equalities Implications:

7.3 By definition ASC services support vulnerable people. It is important that services for vulnerable people are of high quality, and as far as possible, are locally available. In order to ensure that quality and supply are both maintained, BHCC has very active monitoring and support arrangements as detailed in the main body of the report. These arrangements go well beyond statutory requirements,

and beyond what neighbouring authorities commit to, but they are instrumental in ensuring a relatively high quality and robust ASC market in the city; and hence help guarantee good quality care services for vulnerable residents.

Sustainability Implications:

7.4 None directly to this report. Effectively supporting the Brighton & Hove care market reduces the need to use out of area residential placements, other than as a matter of service user choice. This minimises travel to and from residential settings for families etc.

Brexit Implications:

7.5 None directly to this report. Significant numbers of EU nationals work in the local care sector, and there are consequent risks to the sustainability of the local care market should large numbers of these people choose not to stay in the UK in future years. There is ongoing citywide work to identify and potentially mitigate sectoral exposure to Brexit workforce risks.

Any Other Significant Implications:

Crime & Disorder Implications:

7.5 None identified.

Risk and Opportunity Management Implications:

7.6 Not material for this report for information.

Public Health Implications:

7.7 Effective monitoring of ASC quality helps support people to live good quality lives. This is integral to the Living Well, Ageing Well and Dying Well Brighton & Hove Joint Health & Wellbeing Strategy priorities

Corporate / Citywide Implications:

7.8 Not material for this report for information.

SUPPORTING DOCUMENTATION

Appendices:

1. CQC fundamental standards explanation

2. Quality Monitoring-Quality Assurance Framework

3. Quality Monitoring Team pathway

4. Service Improvement Panel Terms of Reference

5. Care Governance Board Terms of Reference

6. BHCC Suspension Policy

7. Post Survey Report 2019

8. Summary of latest published new approach ratings of active Social Care Organisation locations in Brighton and Hove

Background Documents

None

Appendix 1

(Information taken from CQC website)

CQC Fundamental Standards

Everybody has the right to expect the following standards:

Person-centered care

You must have care or treatment that is tailored to you and meets your needs and preferences.

Dignity and respect

You must be treated with dignity and respect at all times while you're receiving care and treatment.

This includes making sure:

- You have privacy when you need and want it.
- Everybody is treated as equals.
- You're given any support you need to help you remain independent and involved in your local community.

Consent

You (or anybody legally acting on your behalf) must give your consent before any care or treatment is given to you.

Safety

You must not be given unsafe care or treatment or be put at risk of harm that could be avoided.

Providers must assess the risks to your health and safety during any care or treatment and make sure their staff have the qualifications, competence, skills and experience to keep you safe.

Safeguarding from abuse

You must not suffer any form of abuse or improper treatment while receiving care.

This includes:

- Neglect
- Degrading treatment
- Unnecessary or disproportionate restraint
- Inappropriate limits on your freedom.

Food and drink

You must have enough to eat and drink to keep you in good health while you receive care and treatment.

Premises and equipment

The places where you receive care and treatment and the equipment used in it must be clean, suitable and looked after properly.

The equipment used in your care and treatment must also be secure and used properly.

Complaints

You must be able to complain about your care and treatment.

The provider of your care must have a system in place so they can handle and respond to your complaint. They must investigate it thoroughly and take action if problems are identified.

Good governance

The provider of your care must have plans that ensure they can meet these standards.

They must have effective governance and systems to check on the quality and safety of care. These must help the service improve and reduce any risks to your health, safety and welfare.

Staffing

The provider of your care must have enough suitably qualified, competent and experienced staff to make sure they can meet these standards.

Their staff must be given the support, training and supervision they need to help them do their job.

Fit and proper staff

The provider of your care must only employ people who can provide care and treatment appropriate to their role. They must have strong recruitment procedures in

place and carry out relevant checks such as on applicants' criminal records and work history.

Duty of candour

The provider of your care must be open and transparent with you about your care and treatment.

Should something go wrong, they must tell you what has happened provide support and apologise.

Display of ratings

The provider of your care must display their CQC rating in a place where you can see it. They must also include this information on their website and make our latest report on their service available to you.

Last updated:
29 May 2017

Brighton & Hove City Council

Health & Adult Social Care

Quality Monitoring Team Quality Assurance Framework

The Quality Monitoring Team supports contracted Adult Social Care services across the city. The team's role is to monitor the services to ensure that good quality care is provided to keep people safe.

Version:	Final September 2019 (1)
Effective from:	22082019
Review date:	March 2020 (or as required)
Signed off by:	Michelle Jenkins
Title:	Quality Monitoring Team: Quality Monitoring Assurance Framework
Date:	
Author:	Marnie Naylor Quality Monitoring Lead/ Helen Cox/Luke Edmeads/Allison Morrison/Cassie Whitfield/James Wilson

Contents

1. Introduction

1.1 *What is this framework about?*

This document describes Brighton & Hove City Council's (**BHCC**) approach to assuring the quality of care we commission. The framework covers people who are living in a **care home (nursing & non-nursing)**, receiving **support in the community** or any other care support to remain as independent as possible e.g**.** supported living**.** The Quality Assurance Framework will direct how quality of care is measured and responded to by the council's Health & Adult Social Care Quality Monitoring Team (**QMT**). The team works in partnership with other key stakeholders who include; Clinical Commissioning Group (**CCG**), BHCC Commissioners, and Care Quality Commission (**CQC**).

This quality assurance framework provides a comprehensive formalised approach to ensure that good quality care is being provided in the commissioned services stated above. ***Good quality care means that people feel safe, empowered by the services they receive and are enabled to live independent lives as defined by them.*** The QMT will provide an overview of what a 'good' and 'safe' provider service should look like, whilst complying with the council's commissioning & contract arrangements. The QMT provide assurance, and contact with professionals or other key stakeholders where required. For services with significant quality concerns providers will receive support for a non-specific period of time until guarantees are evidenced through quality assurance audits, or CQC (who are the regulator for all 'registered' care providers) inspection reports or both.

Brighton and Hove City Council's, Quality Monitoring Team, and the Clinical Commissioning Group's Clinical Quality Patient Safety Team work closely together to support services which may include carrying out quality monitoring and assurance visits. Both organisations also ensure information is shared with the Care Quality Commission and gather intelligence to prioritise interventions where quality issues are identified.

The teams use a variety of sources of quality-related information and data, as well as listening to staff and those people using services directly, in order to give assurance to key stakeholders.

*To promote mutual respect and openness, most visits (unless unannounced) will be arranged at a convenient time for the provider. Feedback of findings, including recommendations will be sent to the organisation to check for discrepancies and add any comments. The reports once finalised will be shared with the **CQC**, the Local Authority and Commissioners at both **BHCC** and the **CCG**.*

2. Background

2.1 *What is the role of the Quality Monitoring team?*

The **QMT** sits within the council's 'Professional Standards, Safeguarding & Quality Monitoring' Team.

The team is approximately 4.1 full time equivalent staff working Monday-Friday, made up of five team members and one manager.

See Appendix one: *Quality Monitoring Team members and lead areas of responsibility*

A duty system operates throughout the week (Monday-Friday) to ensure any quality issues relating provider services under contract with Health & Adult Social Care (**HASC**), are picked up by team members and dealt with as swiftly as possible.

Role of Quality Monitoring Team

2.2 The **QMT** supports **HASC** contracted services including services provided in-house across the city. The team's role is to monitor that good quality care is provided in services to keep people safe. The team gather information about providers through various means e.g. complaints, compliments, plaudits, S42 enquiries (safeguarding), and one off information from a variety of sources). **QMT** also works closely with other professionals including **CCG** and **CQC** colleagues, to share information to build up a picture of the quality of care services. '. The **QMT** and **CCG** (quality lead/s) use a jointly developed quality assurance audit tool during all quality monitoring assurance audits.

Monitoring is carried out in a two year cycle to include a Desk Top Review (**DTR**) as part of the process. The team's core function includes monitoring services through risk rating themes of concern, carrying out DTR's and new manager meetings.

What happens with the information gathered?

Information gathered helps the **QMT** to look at any themes emerging e.g. poor medication administration, multiple missed calls (community setting), low staffing levels, out of date training records, poor care planning and monitoring systems.

Information gathered is recorded on the diary sheets held for each provider and also transferred to a 'Service Improvement' document. The key data on this document is discussed during a monthly meeting called a Service Improvement Panel (**SIP**) meeting. The meeting is chaired by the **QMT** lead/s and attended by representatives from HASC Commissioning Team, B&H Clinical Commissioning Group, including the Continuing Health Care Team (**CHC**), HASC Assessment Teams, and the Care Matching Team (**CMT**).

Information gathered is held securely in the shared drive with restricted access to specific personnel. Only data that is relevant to the specific functions of the Quality Monitoring Team will be kept.

Where the sharing of information is required, the principles of the Data Protection Act and **BHCC** Information Sharing Policy must be followed. The **QMT** will share information in the spirit of the Care Act principles of integration and mutual co-operation, demonstrating our duty to co-operate with partners.

Role of the Service Improvement Panel (SIP)

See Appendix two: SIP *terms of reference*

2.3 The **QMT** logs the information received, the provider/s is added to the SIP agenda once any themes start to emerge that raise concerns about the quality of care being provided. The SIP discusses the concerns in more detail and SIP members agree the risk rating **R**ed, **A**mber or **G**reen [**RAG**] , but the final say is with the chair/s. Immediate action will be taken for any urgent

situation/s. '**RAG'** rating will also include feedback on the 'key lines of enquiry' (KLOE's) from **CQC** inspections:

- Safe
- Effective
- Caring
- Responsive
- Well-led

Outcomes from monthly **SIP** meetings may include actions for the **QMT** to carry out any of the following:

- A **focused** quality monitoring assurance audit, where officers visit provider services of concern. (E.g. a joint visit with **CCG** quality assurance colleagues to look at medication procedures, medication charts and recording systems in place etc.).

- A **Follow up audit** to review actions from a previous meeting.

- A **full quality monitoring assurance audit** of a service may be requested which follows the principles of the **CQC KLOE's.**
  Any quality monitoring assurance audit may be carried out jointly with CCG colleagues if there are clinical concerns, these visits are to support providers, offering direct input or signposting.
- Hold a **professionals meeting** with or without the provider to discuss issues of concern further, prior to any actions agreed and put into place.

See Appendix three: *Professionals meeting terms of reference*

See Appendix four: *SIP Risk rating table*

See Appendix five: *Types of provider meetings*

Care Governance

2.4 Care Governance: This is a continuous process rather than a single event and is defined as 'A framework through which organisations are accountable for maintaining and improving the quality of their services and safeguarding high standards of care by creating an environment in which good quality care will flourish.'

Care Governance covers **BHCC**'s systems and processes for monitoring services and provides a route for accounting for the quality of services to a governing body and applies to all social care services whether they are contracted externally, provided in house or through a section 75 agreement.

Information gathered through the **SIP** process (**QMT** lead) is fed into a quarterly report for the council's Care Governance Board. This meeting is chaired by the Executive Director of Health & Adult Social Care.

Suspending a service

2.5 On very rare occasions a service may need to be suspended, if a service is suspended this means that no new BHCC funded placements can be made during the suspension period the decision to suspend any new placements in any service will always have the safety and welfare of people who use services at its heart and this will be paramount in all decision making. The decision to suspend is delegated to the Head of Commissioning (Health & Adult Social Care), based on advice from the Service Improvement Panel. In their absence the Director of Adult Social Services will take the decision.

Support during a Suspension: Whilst a service is suspended the **QMT** will work with the provider (to include **CCG** colleagues and commissioners as required) to provide appropriate support to the provider, this may include regular focused visits to check against progress on the actions agreed during professionals meetings.

The **QMT** and **CCG** may also involve other colleagues to support the home e.g. Dementia Care Home in-Reach Team (**CHiRT**), Speech and Language Team (**SALT**) etc.

The **QMT** will regularly feedback on progress to Commissioners and the **CQC**.

For further information about suspensions, please refer to: Health & Adult Social Care Suspension policy and process December 2018

Areas covered by the QMT

2.6 The **QMT** carry out mostly planned audit visits making contact with the provider before they visit, on rare occasions there may be a need to visit a provider unplanned. Currently **QMT** is responsible for the following services that are contracted and commissioned by **BHCC** council:

- Nursing Homes
- Care Homes (non-nursing), including Learning Disability care homes and Working Age Mental Health care homes
- Home Care (main framework providers)
- Supported Living (Learning Disability)
- Acquired Brain Injury (ABI), sensory loss and Physical Disability Services (that fall under supported living or care homes)
- All Adult Social Care In-House services (excluding Hostels)

Areas not covered by the QMT

2.7 The **QMT** does not carry out quality monitoring audits for the following services:

- **Hostel services**: Rough Sleeping and Homeless Support Services Team monitors the contract and quality of all Hostel services.

- **DPS** services (commissioned under the Dynamic Purchasing System known as 'adam') **DPS** providers do not fall under the same review process carried out by the **QMT**, unless required through the SIP process e.g. visit to premises to check systems are in place etc.
- **Non Commissioned Services.**
- **Services commissioned individually** by **CCG** or Continuing Health Care (**CHC**).
- **Day Services** (Day Centres) these are not **CQC** registered.
- **Children's services.**
- **Out of City placements**: however **QMT** do hold information about **CQC** registered services in East and West Sussex.
- **Community Support** and **Service Contracts.**

Can the QMT support quality issues involving individuals?

The **QMT** is unable to support any individual cases e.g. supporting Mrs. X and their family following a complaint about a care home placement. Any individual cases requiring further investigation would be led by the appropriate assessment service.

What happens to Registered Services not commissioned by BHCC?

2.8 The **QMT** collates information for all **registered adult social care** provider services in the city that are not commissioned or do not have a contract with **BHCC**. The **QMT** keeps a record of any safeguarding or other significant issues passed to the team using the **SIP** database: the **QMT** hold individual files on each provider, these are updated as required. For services that are not - commissioned by HASC Commissioning Team any further involvement by the **QMT** must be accepted by the provider e.g. their agreement for **QMT** to carry out a full quality monitoring assurance audit, or to offer advice and support.

How is the QMT role different to a CQC Inspection?

2.9 The role of the Care Quality Commission as an independent regulator is to register health and adult social care service providers in England and to inspect whether or not standards are being met.
The **CQC** monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and publish what they find, including performance ratings to help people choose care. Full details about the role of **CQC** can be found on their website:
http://www.cqc.org.uk/about-us

The HASC QMT are not inspectors, the QMT plays a role to support providers working in partnership with other key stakeholders and signposting where necessary.

3. Working in Partnership

Feedback via Healthwatch visits

3.1 Healthwatch Brighton & Hove is a registered Community Interest Company. The role of Healthwatch Brighton & Hove is a health and social care watchdog run by and for local people. It is independent of the NHS and Brighton and Hove City Council.

Healthwatch Lay Assessors interview people receiving home care from local providers, speaking to residents plus their families about their experience and the quality of service they receive. Lay Assessors feedback that information to Healthwatch who collate and share written reports to Brighton & Hove City Council to ensure the service providers maintain a high quality of care.

BHCC Performance & Business Improvement Team with support from QMT meet with Healthwatch on a regular basis to inform the programme of work for the Lay Assessor interviews. Outcomes of these reports are shared with the relevant provider and the QMT. Providers have the 'Right to Respond' feeding back on any changes or updates that have taken place during and after the time of the report.

This information helps the QMT to determine whether a broader focused quality audit is required e.g. monitoring of staff training records or focusing on medication recording etc.

Health & Safety (Fire Safety Compliance) support

3.2 The Council is responsible to ensure a good quality standard of care and safety is provided in services we commission across the City. The **QMT** has a Service Level Agreement (SLA) with the council's Health & Safety Business Partners, ensuring Health & Safety (**H&S**) and Fire compliance is being met by providers, making recommendations where shortfalls are identified. This enables vital intelligence to be shared to identify any risks to be addressed. The current working arrangement **H&S** business partners carry out 4-6 **H&S** audits of services each calendar quarter, these are requested by the **QMT**.

4. Quality Assurance Framework diagram

It is our vision to ensure that the most vulnerable people in our community get the right care and support in the right place at the right time. The QMT's role is to monitor the services to ensure that good quality care is provided to keep people safe.

5. Appendices

Appendix one: *Quality Monitoring Team members and lead areas of responsibility*

BHCC Health & Adult Social Care Quality Monitoring Team Contact Numbers (September 2019)			
Name	**Number**	**Lead Area of Quality Monitoring**	**Support Role**
Allison Morrison [FT] M-F	01273 293300	• *Learning disability (Joint Lead) • Craven Vale resource centre [In-house]	Learning disability In-house services [LD/ IAH/Wayfield & Ireland Lodge]
Luke Edmeads [PT] T/TH/F	01273 295036	• In-house learning disability services • Independence at Home [In-house service] • Home Care	Nursing Homes
James Wilson [FT] M-F	01273 295035	• Nursing Homes • Wayfield Avenue & Ireland Lodge resource centres [In-house]	OP Care Homes
Helen Cox [PT] M[am]/T/W/TH[am]	01273 290406	• OP Care Homes	ABI/Physical/sensory disability & working age mental health care homes Craven Vale resource centre
Cassie Whitfield [PT] T-F	01273 295341	• *Learning Disability (Joint Lead) • ABI/Physical/sensory disabilities and Working Age Mental health Care Homes	Learning disability Home Care
Marnie Naylor M/T/TH/F	01273 296033	Quality Monitoring Lead for the team	

Appendix Two: SIP *Terms of Reference*

a. To co-ordinate, share and review the information available regarding the quality of Health & Adult Social Care (**HASC**) social care services

b. To focus on those services which have crossed the escalation threshold and require the monthly focus afforded through **SIP** to identify services where concerns regarding quality are evidenced.

c. To ensure robust improvement planning and that these plans are delivered in a timely manner.

d. To support the delivery of improvement plans by linking providers into local programmes that support quality improvement.

e. To recommend enforcement action in relation to contracted services as appropriate.

f. To share arears of development required within the City (for Commissioners to monitor/use data).

g. To establish priorities in relation to available capacity within the Quality Monitoring Team.

h. To report emerging themes re service quality into the broader Care Governance process (Quality Monitoring Report) and share intelligence with CQC and CCG colleagues/other.

i. To report into the Care Governance Board on activity.

Appendix Three: *Professionals Meetings Terms of Reference*

Professionals meetings are used when serious patterns emerge about a service provider, these could be for a variety of reasons:

- Serious/major incident has occurred resulting in hospitalisation/death.
- **CQC** have rated a service as overall inadequate.
- Various accounts of soft intelligence have been received about a service provider from different or the same source over a period of several weeks/months resulting in themes that raise a significant concern.

SIP meetings are used to determine when a 'professionals' meeting may be required. The meetings are aimed to support the provider and to develop comprehensive action plans to improve the service and safety of those using it, subsequently this could lead to a suspension or even a contractual exit plan once all other avenues have been exhausted fully over an agreed period of time.

Appendix Four: *SIP Risk Ranking*

Principles of SIP main table risk ranking for guidance only					
Risk Ranking Category	**Length of time on SIP- progression to-**	**Themes e.g. complaints, section 42 enquiries, whistle blowing etc.**	**CQC Warnings & inspection ratings**	**Other e.g. section 42 enquiry**	**Response**
RED	**6 months>** investigate/initiate holding a 'professionals' meeting, or escalate to next level e.g. suspension process Straight to **RED** (see response column)	Following intervention e.g. QM Team/ Clinical quality monitoring assurance visit themes continue to materialise with no significant improvement	Inadequate Rating : immediate entry level or CQC have issued warning notices and enforcement action	A significant shortfall during investigation relating to safety of others in relation to a provider or Where previous levels of concern have consistently failed to deliver the improvements identified	SIP priorities to include Quality Monitoring assurance visit within 28 days timeframe and continued close monitoring of service
AMBER	**2-6 months** consider moving to Red or Green depending on new evidence provided	Themes are consistent over several months	Requires Improvement in 4+ areas	A moderate shortfall during investigation relating to safety of others in relation to a provider Or Some improvements are still required following being identified	On-going monitoring & support e.g. High level of Falls: falls prevention team input, planned quality assurance visit within 4-8 week timeframe
GREEN	**2 months** removal from main table or move to **Amber** (if no improvements move to Amber 2 months>)	1+ theme/s start to emerge from intelligence gathered	Improvements are made but may have 1-2 requirements still outstanding	Low level concerns during investigation relating to safety of others in relation to a provider Or Minor improvements are still required following being identified	Support from teams Plan a short focused quality monitoring assurance visit within 4-8weeks
Yellow Any service that has served notice to close add to SIP main table, and highlight in Yellow. Treat in the same way as any other service on SIP					

Appendix Five: *Types of Provider Meeting*

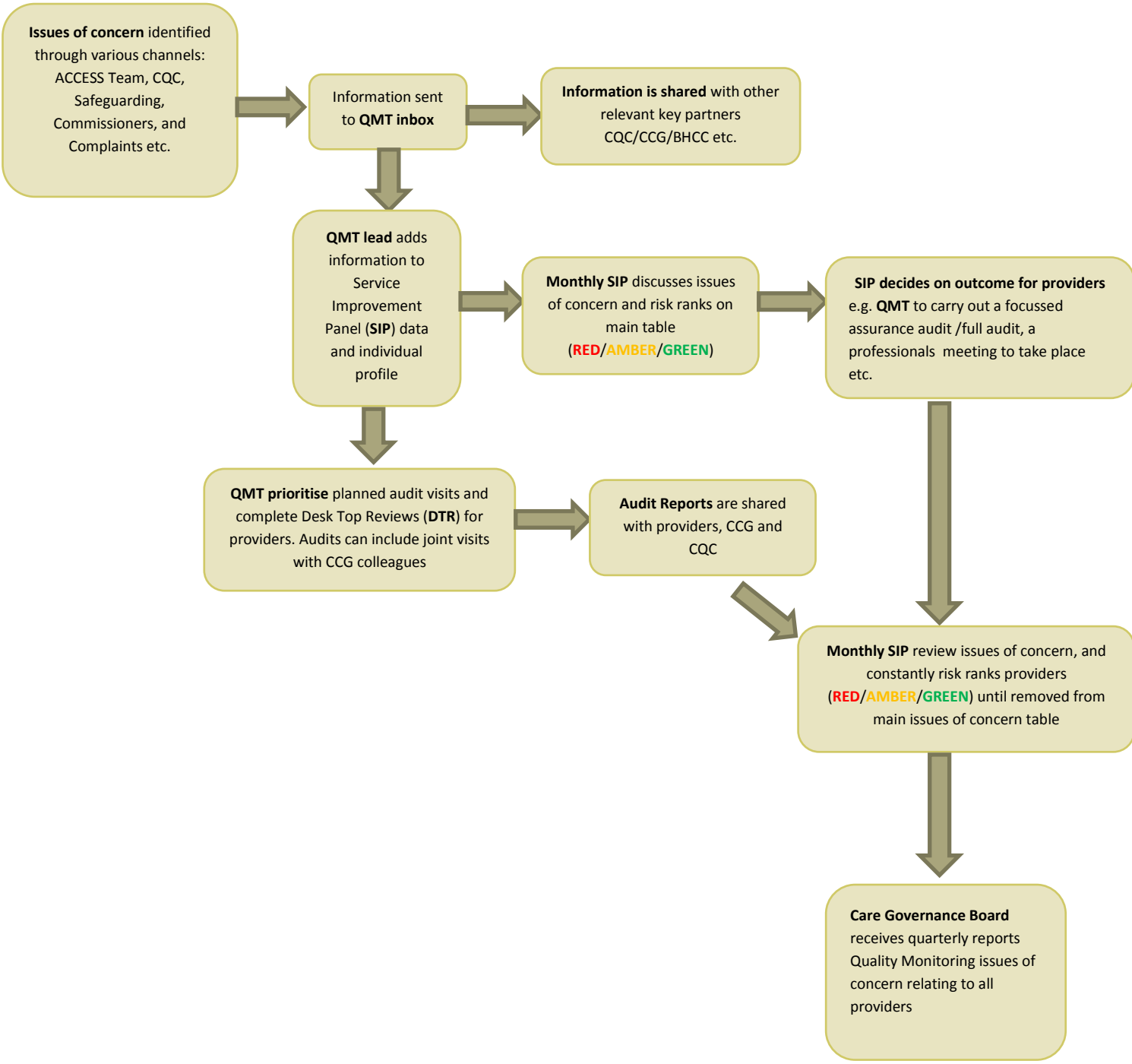
Meeting Name (& length)	When does this meeting take place?	Why does this meeting take place?	Who should attend this meeting?	What should be covered	Any outcomes/ action? – reports – how is it recorded? [all visit documentation to be kept in BHCC monitoring folder for service]	Templates [See forms library]
Quality Monitoring Team Provider Meetings						
1.New Manager/ Introduction meeting **(1 to 2 hours)**	New/ change of manager/ informal or formal one off meetings	Build relationships/ introduce QMT/ Discuss service requirements	• QM CSO • Service Manager	- **New manager's information pack** can be used as agenda - building tour - service update - H&S update (if audit completed)	Currently no formal report/ template. Follow up any queries on either side. Correspondence kept in folder for service.	Confirm date with manager by e-mail
2. Quality Monitoring Assurance Audit (Scheduled) **(1-2 full day/s – Res/ home care/ community support / supported living/ accommodation & shared lives.]** **@ service location.**	Concerns identified via SIP, CQC report or if it is a new service.	Understand service. For HC high value contracts. Identify improvements Pass on good practice/ quality monitoring themes. Offer support to provider/ service.	• QM CSO/s [1 or 2] • Service manager	*In advance:* 1. Send agenda request any relevant paperwork eg.Staff rota. Training matrix. 2. Send staff questionnaires 3. Review diary sheet – [safeguarding/ CQC/ complaints etc.] DTR, CQC, H&S and previous audit reports *On the day* – office review checking paperwork policies, recording, audit systems (incl. medication). Res - look round home. Staff, SU & relative interviews. [NB: CQC time spent @20% looking at	Draft audit report to be written up within **2-4 weeks** of visit including action points with timeframes [NB: advise manager if draft report will be longer than this timescale]. Send draft to Quality Lead for review/comment before sending to provider. Distribute to: service and cc commissioner Ask service to complete online Quality Monitoring visit survey Ask for comments on draft report from provider and give a date for comments to	E-mail service to confirm date. Agenda – use joint template report Joint Template Assurance Audit Report (incl. Action Plan) Ask admin to send Quality Monitoring link for feedback from provider on the visit Questionnaires for Staff, SU Interview forms

Meeting Name (& length)	When does this meeting take place?	Why does this meeting take place?	Who should attend this meeting?	What should be covered	Any outcomes/ action? – reports – how is it recorded? [all visit documentation to be kept in BHCC monitoring folder for service]	Templates [See forms library]
				paperwork and 80% looking at home] Examples of ways to obtain people's views on the day: Have lunch / tea at service, ask people to show you their own rooms, join in an activity, watch or shadow staff.	be returned. Send final version to provider and a copy to CQC : enquiries@cqc.org.uk	
3. Focused Assurance Audit **(half to full day @ service location)**	Specific area of concern/s. Could be highlighted via - CQC - after a safeguarding investigation - whistle-blower - a DTR - theme from SIP - feedback from commissioner/other professional.	As above.	• QM CSO • Service Manager	Areas of concern initially and broaden out if other things discovered/ related: paperwork / interviews. [Preparation and implementation as above.]	As above.	As above.
4. Follow up Visit (2 hours)	Follow on from quality monitoring full or focused assurance audit or after DTR or H&S safety visit. Or -if poor engagement -at provider request	Check improvements have been made/ discuss particular issue. Confirm if actions completed. Or if DTR identifies no visit to service in last 3 years.	• QM CSO • Service Manager	Focused on areas for improvement/ of concern/ provider requested support with. Or if follow up after DTR include general service update, any issue identified via DTR and building tour.	Action plan from previous audit. If DTR follow up meeting take notes and e-mail provider update. This is not shared with CQC.	E-mail to confirm date Action plan in audit report

Meeting Name (& length)	When does this meeting take place?	Why does this meeting take place?	Who should attend this meeting?	What should be covered	Any outcomes/ action? – reports – how is it recorded? [all visit documentation to be kept in BHCC monitoring folder for service]	Templates [See forms library]
Commissioning Team Provider Meetings						
1.Meet & Greet	New provider	To discuss contractual requirements with new providers	• Commissioning team CSO/ or commissioner • Service manager	Contractual obligations		
2. Contract Review **(2 hours)**	Commissioner led - 6 month/ annual review of performance of larger contracts or service contracts.	Past performance and future plans. Contractual requirements. Usually informed by provider report/ PIs	• Commissioner/Commissioning & Performance Manager • Commissioning CSO • Service provider manager and/or reps	Provider report, PIs, PDC. Future plans. Commissioner feedback re: VFM and satisfaction.	Minutes written by CSO including action points.	Contract Review process, including: Letter Agenda Minutes Provider Document Checklist Contract Review checklist

Appendix 3

Quality Monitoring Team (QMT) Pathway Diagram. (QMT monitors the provider and not individuals)



Appendix 4

The Service Improvement Panel (SIP)
Terms of Reference

SIP Membership (January 2017): Marnie Naylor (Quality Monitoring Lead and lead for SIP/Chair), Michelle Jenkins (Head of Professional Standards, Safeguarding & Quality Monitoring:Chair), Carol Hards (CCG), Tracey Mansell (CMT) Christian Smith (Homecare), Claire Machin (Assessment lead) Rai Brady (SPFT: SOAMHS) David Allerton (SPFT: functional adults), Claire Pritchard (CCG-CHC), Claire Rowland (lead Commissioner), Lisa Akmenkalns (commissioner-homecare and care homes), Pam Lelliott (minute taker) to include a member of the QM Team rep tbc each month
Minutes to be circulated to: All of the above, and Andy Witham (head of commissioning), Richard D'Souza (Service Manager SPFT), Ian Wilson (CCG).

1. **Terms of Reference**
    a. To co-ordinate, share and review the information available regarding the quality of Health & Adult Social Care (HASC) social care services
    b. To focus on those services which have crossed the escalation threshold and require the monthly focus afforded through SIP identify services where concerns regarding quality are evidenced.
    c. To ensure robust improvement planning and that these plans are delivered in a timely manner.
    d. To support the delivery of improvement plans by linking providers into local programmes that support quality improvement.
    e. To recommend enforcement action in relation to contracted services as appropriate.
    f. To share unmet needs within the City (for Commissioners to monitor/use data)
    g. To establish priorities in relation to available capacity within the Quality Monitoring Team: QMT.
    h. To report emerging themes re service quality into the broader Care Governance process (Quality Monitoring Report) and share intelligence with CQC and CCG colleagues/other.
    i. To report into the Care Governance Board on activity.

2. The Service Provider Profile, held by the Quality Monitoring Team (QMT) will hold relevant intelligence about provider services, this will include information relating to but not exhaustive:

    - Safeguarding (causes for concern & section 42 enquiries)
    - Complaints
    - Whistleblowing
    - CQC feedback/inspection reports
    - Information gathered by others e.g. soft intelligence
    - Commissioning Feedback/concerns

3. In most instances the levels of concern discussed will be of a level that improvement activity will be monitored directly within the QM Team, working with Commissioners and those responsible for the contract element. The broad themes and trends from this will be fed into the SIP and feed into the quarterly Quality Monitoring Report shared at quarterly Care Governance Meetings. The report will be available in the public domain as required.

4. However sometimes the level of concern will require escalation into the SIP such that the service is subject to monthly review by the SIP in relation to improvement planning and actions that maybe required by the Council in relation to this.

5. Escalation into the SIP will usually be a matter of judgement for the panel members in each instance. The following factors will be of relevance ;

a. Where a section 42 investigation has led to a significant shortfall during investigation relating to the safety of others in relation to a provider then escalation into SIP will take place automatically
b. Where the CQC have issued warning notices and enforcement action then escalation into SIP will automatically take place
c. The breadth of the concerns re quality and their impact on people using the service
d. The confidence in a provider to deliver improvements
e. Where previous levels of concern have not escalated into SIP but the provider has consistently failed to deliver the improvements identified.
f. Themes emerging about a service through various avenues e.g. complaints, section 42 enquiries, whistle blowing etc.
g. When a home is closing/terminating its business

6. The SIP will :

a. Agree on risk ranking of services and any immediate actions to follow e.g. the Quality Monitoring Team to carry out a focussed visit, a multi-disciplinary meeting to be convened etc.
b. Monitor progress each month against the improvement plans of specific service providers
c. Identify available supports across the care system that may assist the provider (e.g. training programmes , best practice, dignity groups, quality assurance groups, health support)
d. Identify any enforcement actions required in relation to the contract for service (working closely with those responsible for contract management).

7. The SIP will meet monthly but responses to any concerns re quality need to be timely and need not wait until the SIP meets. The SIP will provide a monthly overview of activity and priorities.

8. Principles of SIP: guidance for the members when to add or remove from the main risk ranking table (Red/Amber/Green), when to initiate ‘professionals meetings etc.
See appendix one

Appendix one

Principles of SIP main table risk ranking for guidance only					
Risk Ranking Category	**Length of time on SIP-progression to-**	**Themes e.g. complaints, section 42 enquiries, whistle blowing etc.**	**CQC Warnings & inspection ratings**	**Other e.g. section 42 enquiry**	**Response**
RED	**6 months>** investigate/initiate holding a 'professionals' meeting, or escalate to next level e.g. suspension process Straight to **RED** (see response column)	Following intervention e.g. QM Team/ Clinical quality monitoring assurance visit themes continue to materialise with no significant improvement	Inadequate Rating : immediate entry level or CQC have issued warning notices and enforcement action	A significant shortfall during investigation relating to safety of others in relation to a provider or Where previous levels of concern have consistently failed to deliver the improvements identified	SIP priorities to include Quality Monitoring assurance visit within 28 days timeframe and continued close monitoring of service
AMBER	**2-6 months** consider moving to Red or Green depending on new evidence provided	Themes are consistent over several months	Requires Improvement in 4+ areas	A moderate shortfall during investigation relating to safety of others in relation to a provider Or Some improvements are still required following being identified	On-going monitoring & support e.g. High level of Falls: falls prevention team input, planned quality assurance visit within 4-8 week timeframe
GREEN	**2 months** removal from main table or move to **Amber** (if no improvements move to Amber 2 months>)	1+ theme/s start to emerge from intelligence gathered	Improvements are made but may have 1-2 requirements still outstanding	Low level concerns during investigation relating to safety of others in relation to a provider Or Minor improvements are	Support from teams Plan a short focussed quality monitoring assurance visit within 4-8weeks

				still required following being identified	

Yellow
Any service that has served notice to close add to SIP main table, and highlight in Yellow. Treat in the same way as any other service on SIP

Updated March 2017 Marnie Naylor & Carol Hards

Appendix 5

The Service Improvement Panel (SIP)
Terms of Reference

SIP Membership (June 2019): Marnie Naylor (Quality Monitoring Lead and lead for SIP/Chair), Michelle Jenkins (Head of Professional Standards, Safeguarding & Quality Monitoring: Chair), Carol Hards (CCG), Isabelle Kay (CCG), Tracey Mansell (CMT), Claire Machin (Assessment lead),(**SPFT: SOAMHS rep TBC each meeting**) David Allerton (SPFT: functional adults), CCG-CHC rep, Claire Rowland (lead Commissioner)-Alex Saunders (covering CR), Lisa Akmenkalns (commissioner-homecare and care homes), Alex Morris (CCG safeguarding lead), **CLDT REP**, Lou Aish (CLDT Commissioner or Jenny Cain),Michael Malone (minute taker) to include a member of the QM Team rep tbc each month

Minutes to be circulated to: All of the above: Andy Witham (head of commissioning), Richard D'Souza (Service Manager SPFT), Ian Wilson (CCG), Candy Gallinagh (CHC), Richard Stevenson, Liam Sargent

1. **Terms of Reference**
    a. To co-ordinate, share and review the information available regarding the quality of Health & Adult Social Care (HASC) social care services.
    b. To focus on those services which have crossed the escalation threshold and require the monthly focus afforded through SIP to identify services where concerns regarding quality are evidenced.
    c. To ensure robust improvement planning and that these plans are delivered in a timely manner.
    d. To support the delivery of improvement plans by linking providers into local programmes that support quality improvement.
    e. To recommend enforcement action in relation to contracted services as appropriate.
    f. To share arears of development required within the City (for Commissioners to monitor/use data).
    g. To establish priorities in relation to available capacity within the Quality Monitoring Team: QMT.
    h. To report emerging themes re service quality into the broader Care Governance process (Care Governance quarterly Report) share intelligence with CQC and CCG colleagues/other.
    i. To report into the Care Governance Board on activity.

2. The Service Provider Profile, held by the Quality Monitoring Team (QMT) will hold relevant intelligence about provider services, this will include information relating to but not exhaustive:

    - Safeguarding (causes for concern & section 42 enquiries)
    - Complaints
    - Whistleblowing
    - CQC feedback/inspection reports

- Information gathered by others e.g. soft intelligence
- Commissioning Feedback/concerns

3. In most instances the levels of concern discussed will be of a level that improvement activity will be monitored directly within the QM Team, working with Commissioners and those responsible for the contract element. The broad themes and trends will be shared during monthly SIP meetings and feed into the quarterly Quality Monitoring Report shared at quarterly Care Governance Meetings. The report will be available in the public domain as required.

4. However sometimes the level of concern will require escalation into the SIP such that the service is subject to monthly review by the SIP in relation to improvement planning and actions that maybe required by the Council in relation to this.

5. Escalation into the SIP will usually be a matter of judgement for the panel members in each instance. The following factors will be of relevance ;

a. Where a section 42 investigation has led to a significant shortfall during investigation relating to the safety of others in relation to a provider then escalation into SIP will take place automatically.
b. Where the CQC have issued warning notices and enforcement action then escalation into SIP will automatically take place.
c. The breadth of the concerns re quality and their impact on people using the service.
d. The confidence in a provider to deliver improvements.
e. Where previous levels of concern have not escalated into SIP but the provider has consistently failed to deliver the improvements identified.
f. Themes emerging about a service through various avenues e.g. complaints, section 42 enquiries, whistle blowing etc.
g. When a home is closing/terminating its business.

6. The SIP will :

a. Agree on risk ranking of services and any immediate actions to follow e.g. the Quality Monitoring Team to carry out a focussed visit, a multi-disciplinary meeting to be convened etc.
b. Monitor progress and feedback as required each month against the improvement plans of specific service providers.
c. Identify available support across the care system that may assist the provider (e.g. training programmes, best practice, dignity groups, quality assurance groups, health support).
d. Identify any enforcement actions required in relation to the contract for service (working closely with those responsible for contract management).

7. The SIP will meet monthly but responses to any concerns re quality need to be timely and need not wait until the SIP meets. The SIP will provide a monthly overview of activity and priorities.

8. Principles of SIP: guidance for the members when to add or remove from the main risk ranking table (Red/Amber/Green), when to initiate 'professionals meetings etc.
See appendix one

9. Sharing of sensitive information between organisations (**G**eneral **D**ata **P**rotection **R**egulation) added June 2019. Below are some basic principles that SIP must follow in keeping with the GDPR Act 2018:
    a. Be clear what information is being shared for?
    b. Ensure any guidance reflects expectations of privacy at work which is not the same as a private setting (staff names).
    c. People using a service; their name can be included in sharing of information if the impact on an individual case is in order to do what we need to do. Where possible names will not be included or shared in any data, unless the above applies.
    d. If a setting is at potential risk it is reasonable to share as much information as is reasonable example CQC serving notice.
    e. Information shared is relevant, not too little, and not too much. The panel to decide what information is recorded and shared.
    f. Include in any guidance why we keep information; how things are working and looking for improvements and sharing of knowledge to improve services. The Quality Monitoring Team's quality assurance framework clearly states the purpose of record keeping, monitoring of services to improve quality of care.

Data protection regulations SIP must follow under the lawful data act:

- **GDPR Article 9: 1:** Processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation **shall be prohibited**
- **GDPR Article 9 (2g)** processing is necessary for reasons of substantial public interest, on the basis of Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject;

http://www.privacy-regulation.eu/en/article-9-processing-of-special-categories-of-personal-data-GDPR.htm

- **Data Protection Act, schedule 1** Health or social care purposes
    1. This condition is met if the processing is necessary for health or social care purposes.
    2. In this paragraph "health or social care purposes" means the purposes of—
    a. preventive or occupational medicine,
    b. the assessment of the working capacity of an employee,
    c. medical diagnosis,
    d. the provision of health care or treatment,
    e. the provision of social care, or
    f. the management of health care systems or services or social care systems or services.

    Safeguarding of economic well-being of certain individuals 19(1) This condition is met if the processing—
    a. is necessary for the purposes of protecting the economic well-being of an individual at economic risk who is aged 18 or over,
    b. is of data concerning health,

c. is carried out without the consent of the data subject for one of the reasons listed in sub-paragraph (2), and
d. is necessary for reasons of substantial public interest.

(2)The reasons mentioned in sub-paragraph (1)(c) are—

a. in the circumstances, consent to the processing cannot be given by the data subject;

b. in the circumstances, the controller cannot reasonably be expected to obtain the consent of the data subject to the processing;

c. the processing must be carried out without the consent of the data subject because obtaining the consent of the data subject would prejudice the provision of the protection mentioned in sub-paragraph (1)(a).

(3)In this paragraph, “individual at economic risk” means an individual who is less able to protect his or her economic well-being by reason of physical or mental injury, illness or disability.

http://www.legislation.gov.uk/ukpga/2018/12/schedule/1/enacted

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Appendix one

Principles of SIP main table risk ranking for guidance only					
Risk Ranking Category	**Length of time on SIP- progression to-**	**Themes e.g. complaints, section 42 enquiries, whistle blowing etc.**	**CQC Warnings & inspection ratings**	**Other e.g. section 42 enquiry**	**Response**
RED	**6 months>** investigate/initiate holding a 'professionals' meeting, or escalate to next level e.g. suspension process Straight to **RED** (see response column)	Following intervention e.g. QM Team/ Clinical quality monitoring assurance visit themes continue to materialise with no significant improvement	Inadequate Rating : immediate entry level or CQC have issued warning notices and enforcement action	A significant shortfall during investigation relating to safety of others in relation to a provider or Where previous levels of concern have consistently failed to deliver the improvements identified	SIP priorities to include Quality Monitoring assurance visit within 28 days timeframe and continued close monitoring of service
AMBER	**2-6 months** consider moving to Red or Green depending on new evidence provided	Themes are consistent over several months	Requires Improvement in 4+ areas	A moderate shortfall during investigation relating to safety of others in relation to a provider Or Some improvements are still required following being identified	On-going monitoring & support e.g. High level of Falls: falls prevention team input, planned quality assurance visit within 4-8 week timeframe
GREEN	**2 months** removal from main table or move to **Amber** (if no improvements move to Amber 2 months>)	1+ theme/s start to emerge from intelligence gathered	Improvements are made but may have 1-2 requirements still outstanding	Low level concerns during investigation relating to safety of others in relation to a provider Or Minor improvements are still required following	Support from teams Plan a short focussed quality monitoring assurance visit within 4-8weeks

				being identified	

Yellow
Any service that has served notice to close add to SIP main table, and highlight in Yellow. Treat in the same way as any other service on SIP

Updated March 2019 Marnie Naylor & SIP representatives

Appendix 6

Brighton & Hove City Council

Brighton & Hove City Council

Health & Adult Social Care Suspension Policy & Process

Policy & Process for : Suspending a Service, and Lifting a Suspension in Residential, Nursing Care and Care packages with Supported Living and Domiciliary Care Agencies due to concerns regarding quality of care

December 2018

Brighton & Hove City Council's Health & Adult Social Care Directorate and the NHS Clinical Commissioning Group are committed to promoting high quality and safe care within the care and support market. Brighton & Hove City Council's (BHCC) Health & Adult Social Care (HASC) Directorate and NHS Clinical Commissioning Group (CCG) operates a process to share information around concerns regarding commissioned services for the purpose of safeguarding vulnerable adults and supporting quality improvement within the care market.

The purpose of this Policy and Process is to make sure the process for a suspension of services is open and transparent for the provider, those using the service to be suspended and partner agencies.

The Local Authority is responsible for leading any safeguarding enquiries required, in line with the Sussex Safeguarding Adults Policy and Procedures.
http://sussexsafeguardingadults.procedures.org.uk/

Definition of a Suspension

Where the Commissioners, in consultation with other stakeholder and agencies where appropriate, have established serious concerns relating to the quality of service delivery, the Commissioners have a duty of care not to commission any new care services from that provider until satisfactory resolution of the concerns is obtained.

Suspending Placements in Social Care Services

1. The decision to suspend new placements in any service will always have the safety and welfare of people who use services at its heart and this will be paramount in all decision making;
2. The decision to suspend is delegated to the Head of Commissioning (Health & Adult Social Care). In their absence the Director of Adult Social Services will take the decision;
3. The decision making on this matter will be undertaken in line with this Policy across all services including BHCC (in house) provision and block contracts;
4. The decision to suspend placements will be made on a case by case basis and will always be a matter of judgement;
5. The following are some of the factors that will influence decision making (always acknowledging point 1 above):
    a. The outcome of Care Quality Commission (CQC) Compliance Reviews in services that are regulated. Particular weight will be given to circumstances where the CQC have identified a service with a rating of overall 'Inadequate' or 3 consecutive overall ratings of 'Requires Improvement' or more major concerns as part of their compliance monitoring and which have a direct impact on the safety and wellbeing of service users;
    b. A Safeguarding Professionals meeting identifies suspension as an important element of a protection plan;

c. The Service Improvement Panel (SIP) rates a provider to be poor in relation to clinical care and overall safety following extensive quality monitoring auditing and support;

d. The cumulative weight of evidence that is gathered over time through the Care Governance Process linked to the severity and pattern and trend of concerns;

e. The level of confidence in the service provider to deliver timely and sustained improvements;

f. Serious concerns about the financial viability of the service provider such that further placements may place potential residents or those receiving a package of care in the community at serious risk of uncertainty and change in the provision of care.

6. Where appropriate the suspension of placements may be limited in its scope to some certain types of placement;

7. Evidence regarding poor quality in care will be communicated with service providers at all times as early and as fully as possible. This should support providers taking early action in relation to concerns and avert the level of concern escalating to the point where new placements are suspended. Where the intention is to suspend from making new placements the evidence behind this will be shared as fully as possible with providers. However there maybe occasions, particularly in relation to complex safeguarding enquiries where the Council cannot share all the information it has to hand at the point of suspension;

8. The decision to suspend from making new placements will be formally communicated to providers in writing;

9. Service providers will be requested to produce an improvement plan which will be approved by, and monitored by the lead Commissioner and Quality Monitoring Teams; and through the Care Governance Framework. The suspension will be lifted once sustainable improvements are evidenced such that the quality of care and safety of residents can be assured. The care and safety of existing service users will be a key focus in relation to improvement planning;

10. Where service providers are having difficulties in sustaining service quality this should be communicated by the service provider to service users and their families alongside plans for improvement;

11. The Council recognises the impact on providers when new placements are suspended particularly if this becomes prolonged. The Council will complete any outstanding investigations and monitor improvement plans in a timely manner. The Council will seek to support providers in developing improvement plans, linking them into training and quality assurance opportunities and highlight best practice examples where possible;

12. The decision to suspend new placements and the lifting of this decision will be communicated to:

a. HASC Assistant Director/s (Assessment) so they can consider action in relation to those people currently using the service;

b. The Head of Delivery (Provider) if this involves an in house service;

c. Relevant Commissioners, including Clinical Commissioning Group if relevant, so they are aware of the issues and this intelligence informs their commissioning plans;

d. The Care Matching Team;

e. The Care Quality Commission in the context of the protocol on information sharing between Councils and the CQC;

f. Other Local Authorities who are using the service;

g. The Director of Adult Social Services and the Lead Member for Health and Adult Social Care

Lifting of Suspensions

While a suspension is in place the situation will be reviewed on a regular basis at the monthly Service Improvement Panel. If at any point during the review process it is considered that the Provider has made significant improvements and this can be evidenced against the Service Improvement Action Plan, then the Head of Commissioning may decide to lift the Suspension with immediate effect.

Monitoring of the service following the lifting of a suspension will continue through the Service Improvement Panel until the Panel is in agreement this is no longer required.

Relevant information and any decision taken to lift a suspension will be shared with all relevant parties.

Suspension Process : Supporting evidence when decision making to suspend a service. Soft intelligence can be gathered in a variety of ways as described in the diagram below: ***(please note this is not an exhaustive list)***

Issues identified

- Issues of concern identified through a variety of intelligence e.g. section 42 safeguarding enquiry, CQC rating, whistleblowing, complaint, Contract reviews, KPI's etc. Information is documented by the Quality Monitoring Team (**QMT**) and added to the Service Improvement Panel **(SIP)** agenda or addressed by Commissioners through Contract reviews.

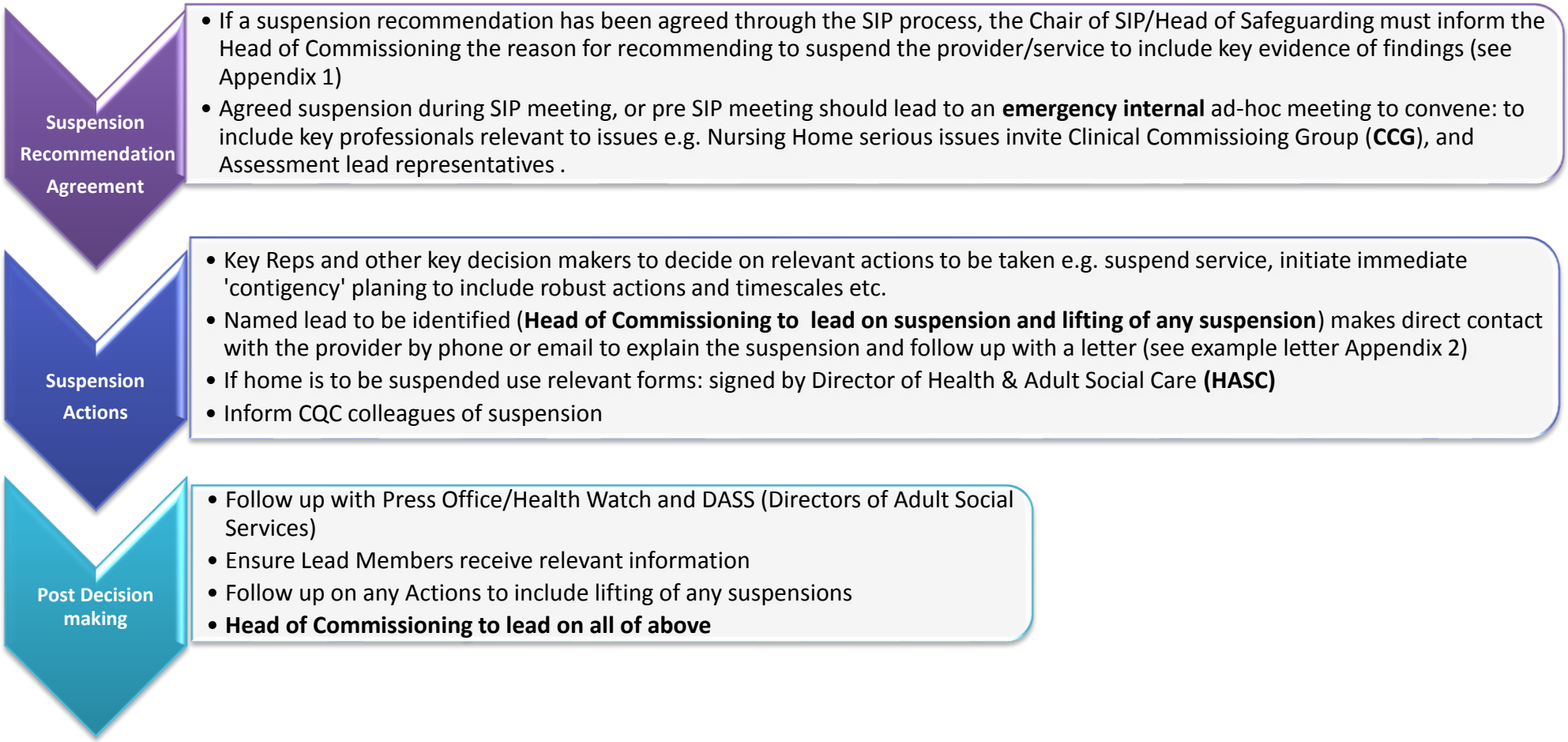
Information discussed during SIP

- The **SIP** members discuss all relevant issues of concern for the current month and risk rank accordingly (**RED/AMBER/GREEN**) lower level issues of concern are 'noted' only e.g. updated info only and not included into the main risk ranking 'RAG' table.
- SIP members make recommendations on any further action to be taken e.g. Quality Monitoring focussed audit to take place, hold a 'professionals' meeting.

Reasons to suspend a service provider

- If a service receives an **'Inadequate'** overal CQC rating this will lead to an automatic suspension
- If a service is under CQC 'Special measures' for any reason
- Other considerations to take into account when looking at suspending a provider/service: Service has been risk ranked as **RED** for 6 months plus, with little or no progress when auditing
- Professionals meeting has taken place and follow up actions have not been met
- Significant Safeguarding concerns received that warrant automatic suspension
- Significant Health & Safety concerns
- Failure to meet Contractual requirements
- A mixture of all of the above
- Another Local Authority has suspended a provider this will lead to an automatic suspension in support to the host authority

Suspension Process: *The below diagram explains what happens once a suspension has been agreed*

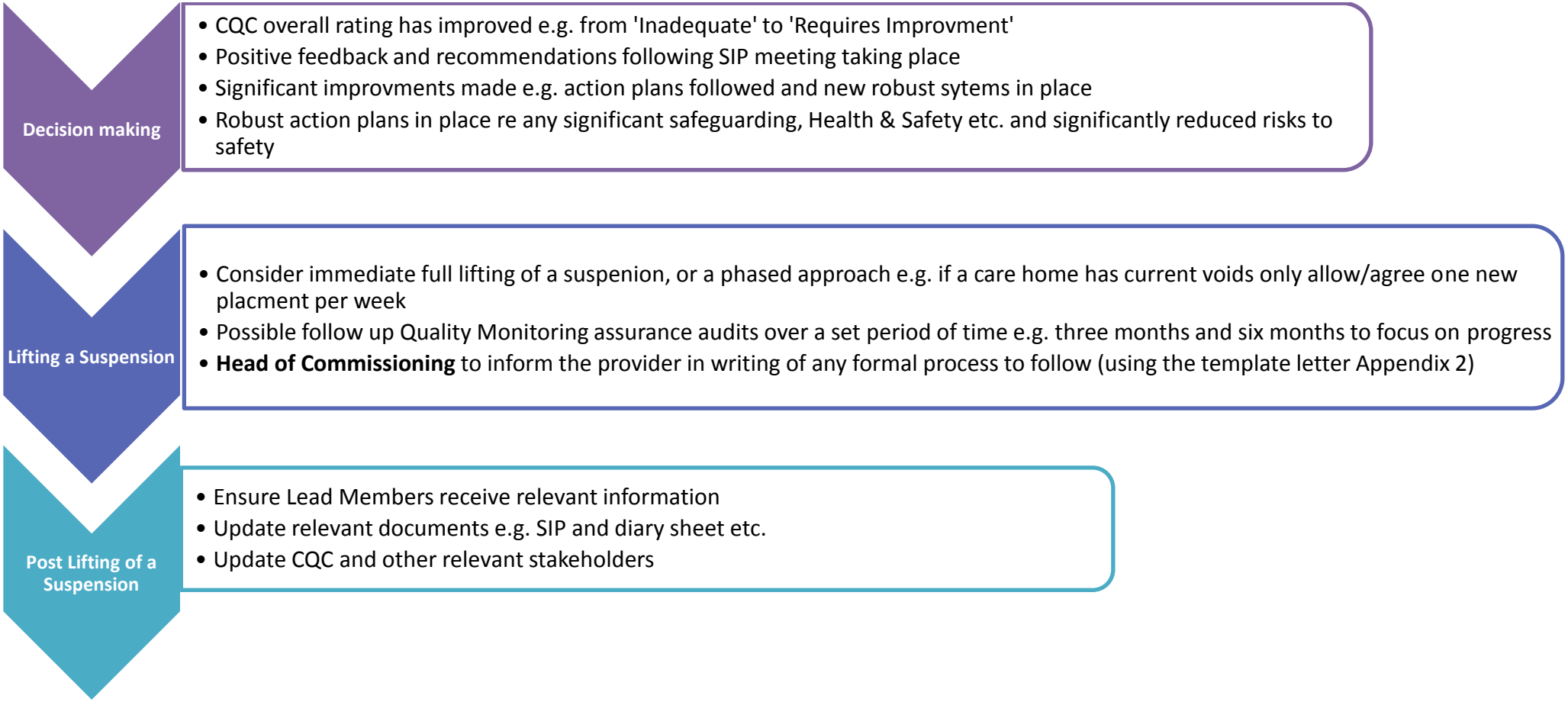


Support during a Suspension: Whilst a service is suspended the Quality Monitoring Team (QMT) will work with the provider (to include CCG colleagues as required) to provide appropriate support to the provider, this may include regular 'focussed' visits to check against progress on the

actions agreed during professionals meetings. The QMT/CCG may also involve other colleagues to support the home e.g. Dementia In-Reach Team, Speech and Language Team (SALT) etc.

The QMT will feedback regularly to Commissioners and the CQC of progress.

<u>Lifting of a Suspension</u>: *Process to follow resulting in the lifting of a suspension or other short/long term emergency intervention led by Head of Commissioning* ***(Please note: this is not an exhaustive list when considering lifting a suspension)***



Appendix 1 – Decision making to Suspend/Lift a Suspension

Health & Adult Social Care

Risk Analysis To Support Suspension Decision Making

Provider Information:			
Provider Name/Parent Company:		**Provision Type and Capacity**	
Name of Registered Manager/Deputy:		**No. of existing BHCC placements**	
Responsible Person/Director:		**Current Vacancies**	
Provider Address:			
Form completed by:		**Date of completion:**	

Existing QM Intelligence:	
Last QM Visit	
QM Officer	
CCG Feedback (impact of suspension on sourcing)	
Other Feedback (lead Ops, Safeguarding, SPFT etc.)	
CQC Feedback: an overall **'Inadequate'** CQC rating leads to an automatic suspension	

Background to this suspension consideration:

Risk Analysis:	
How has the provider acknowledged and responded to concerns?	
Is there an action plan, and if so has any progress been made?	
Has the provider demonstrated a commitment to working in partnership with BHCC/ CCG etc.?	
Describe how a suspension may contribute to or enhance people's safety?	
If suspension is not to go ahead describe any alternative measures that can be put into place?	

Suspension Outcome:		
Recommendation:	Suspend	Do Not Suspend
Review date (if applicable)		
Head of Commissioning:	Signed	Dated

Appendix 2 ; Example letters that could be sent to providers to suspend/lift a suspension

Example: Suspension Letter: To include Headed Paper

Name of Responsible Individual
xxxxx

Address of Provider
xxxxxx
xxxxxx
xxxxxx

Post Code
xxxxx

Date (**day/month/year**)

Dear **xxxxx**,

Re: Add Name of provider/ type of service provided/ contract number if applicable/ reason (e.g. Suspension of Home Care provision) and date

I am writing to you following (**meeting held, recent CQC overall rating, telephone conversation etc.)**
Brighton and Hove City Council will be refraining from making new placements with **xxxxxx** through the **xxxxxx** Contract no **xxxx** until further notice.

This is because **add reason briefly here**

Regarding this matter I would be very grateful if you would provide **xxxxx (add contact name and details)** with (**add any details required e.g. number of residents)** and such as those funded by other local authorities or residents paying for their own placement.

Though timescales cannot be given with regard to how long it will be before Brighton and Hove City Council referrals are resumed, we will be in communication with you regarding how things progress.

Yours sincerely,

Head of Commissioning & Performance (Health and Adult Social Care)

Example: Lifting a Suspension Letter: To include Headed Paper

Name of Responsible Individual
xxxxx

Address of Provider
xxxxxx
xxxxxx
xxxxxx

Post Code
xxxxx

Date (**day/month/year**)

Dear **xxxxx**,

Re: Add Name of provider/ type of service provided/ contract number if applicable/ reason (e.g. Suspension of Home Care provision) and date

Following suspending **xxxxx**, on (**add date**) I am pleased to hear that (**add context e.g. you are no longer rated by CQC as overall 'Inadequate' significant progress has been made against actions required etc.)**

I have reviewed the information you have shared and at this stage and I am pleased to inform you that the current suspension will be lifted on (**add date**).

If needed you could add a caveat e.g. requirements still to be achieved are set out below: This could include a phased approach to lift the suspension

Yours sincerely,

Head of Commissioning & Performance (Health and Adult Social Care)

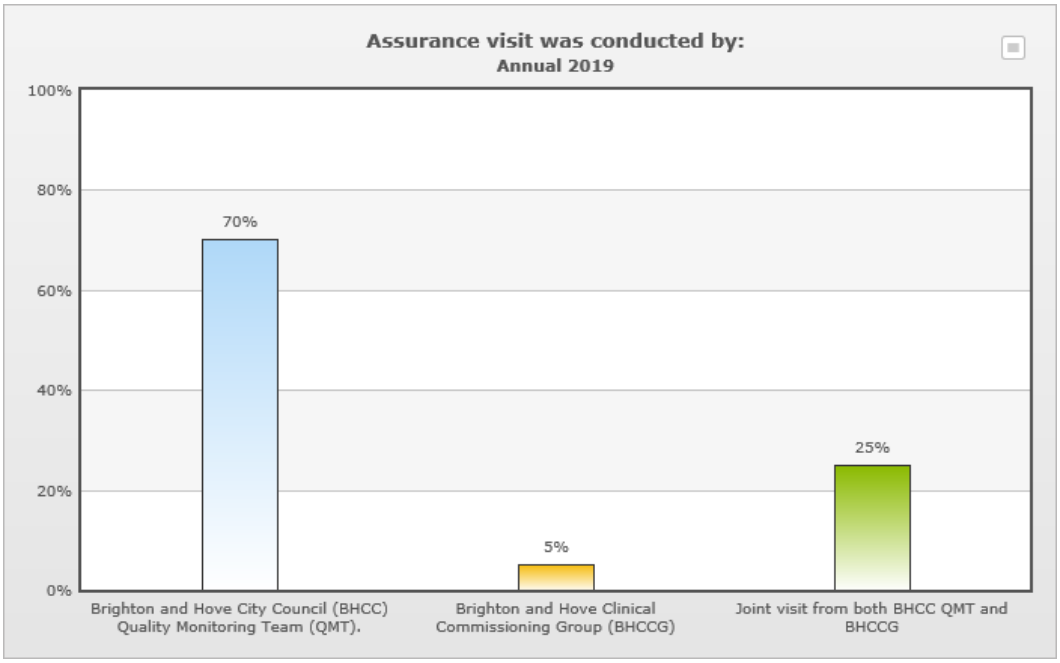
Appendix 7

Quality Monitoring
Post Visit survey results Annual 2019

Summary of surveys sent and received

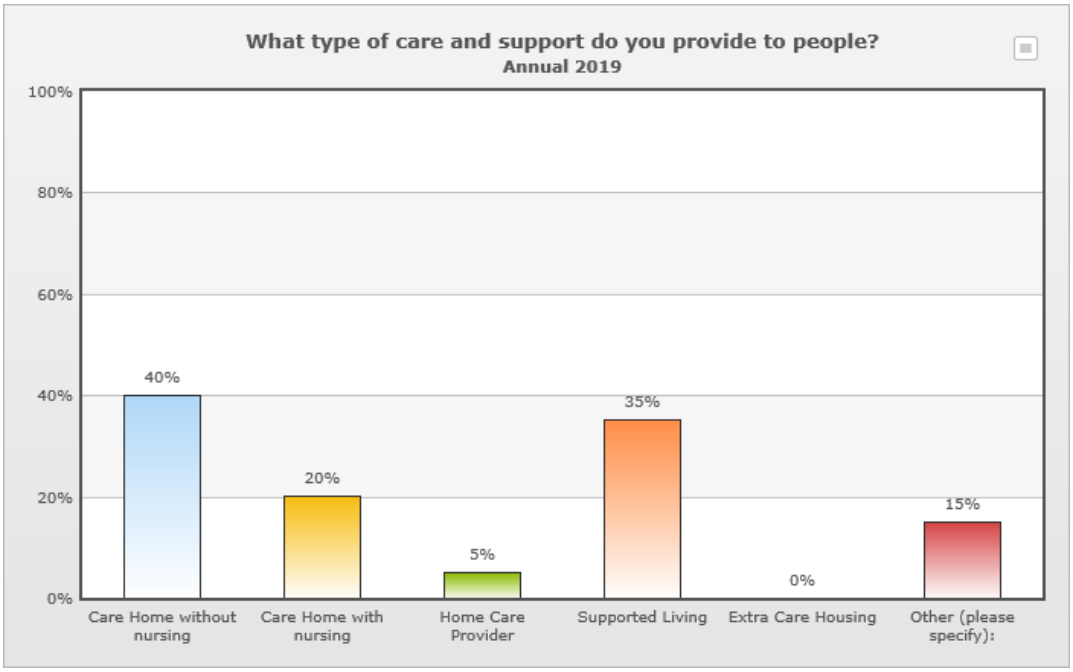
Number of:	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Visits	2	1	3	3	2	5	6	3	5	7	11	7	55
Sent	0	1	2	3	1	5	6	3	5	7	11	6	50
Received	1	0	1	0	0	2	1	3	1	2	4	5	20
Percentage		0	50	0	0	40	16.7	100	20	28.6	36.3	83.3	40

NB: During the period Jan to May, only audits were sent surveys and therefore the number of visits does not include new manager etc.



Appendix 7

Quality Monitoring
Post Visit survey results Annual 2019



3. What was most helpful about the assurance visit?

15/01/19	Luke's approach, knowledge and thoroughness. Luke also provided some good information to further assist myself and my team
04/03/19	The positive feedback, looking at the previous recommendations and feedback with future improvements.
24/06/19	It was informal which made staff relax and go about their business as if there was no visit.
27/06/19	That we met and understood and were given the opportunity to raise issues. But also to be given assurance they are not concerned about our service.
05/07/19	The visit is a introduction of the new quality team
16/08/19	Signposting to other relevant services to support the development of the home and the discussions held about best practice at the visit.
20/08/19	To have a space to confirm queries
20/08/19	The chance to discuss various issues, and get feedback about best practice
29/09/19	To be able review current policies and procedures and have an external view of are current care a support packages. Having time to talk with the team about the future of supported living.
04/10/19	It keeps me updated on any changes about CQC and also to see how we are doing as a team and what we need to improve on
14/10/19	Knowing there is support for the Service
20/11/19	Feed back and openness to discuss matters.
20/11/19	Always good to have another view on the documentation
20/11/19	Very positive, relaxed visit, lots of discussion around the work we were doing rather than checking of files/documents. Ability to discuss work issues and future plans.
22/11/19	As a new Manager I felt very supported by Helen Cox's throughout her visit.
18/12/19	we were informed about what was happening in depth and our professional information was taken into consideration
18/12/19	Having the support of Helen, knowing I can ask if I need help or assistance with

Appendix 7

Quality Monitoring
Post Visit survey results Annual 2019

	anything
20/12/19	Overview provided of the role of the QMT. - Opportunity for us as a provider to outline what it is that we do.
20/12/19	Its nice to see people from the group, helps you to feel in touch, and you get good advice.
31/12/19	To review our process against the check list, verbal feedback given about the service performance.

Appendix 7

Quality Monitoring
Post Visit survey results Annual 2019

4. What was least helpful about the assurance visit?

15/01/19	N/A
04/03/19	N/A
24/06/19	Nothing
27/06/19	Nothing really. Just time that is valuable - but hopefully we shall have a report that is helpful and a good reflection of the work we do.
05/07/19	None
16/08/19	I found all aspects of the visit helpful
20/08/19	Nothing
20/08/19	Nothing I can think of
29/09/19	Not having more time to go over individual policies to discuss and look at changes that could be made.
04/10/19	Nothing
14/10/19	Nothing
20/11/19	All was helpful
20/11/19	n/a
20/11/19	Nothing really
22/11/19	I found the visit very positive
18/12/19	nothing
18/12/19	Nothing it was all helpful
20/12/19	Limited time to discuss the role our service plays in the community and landscape of commissioned services. -Notes taken from the visit by the QMT were inaccurate, though we were able to rectify these.
20/12/19	Nothing
31/12/19	Building the relationship with the BHCC and have an up to date knowledge of BHCC requirements, and also support available.

Appendix 7

Quality Monitoring
Post Visit survey results Annual 2019

5. Do you have any suggestions on how the assurance visit could be improved?

15/01/19	N/A
04/03/19	I found the visit very constructive and supportive.
24/06/19	No, the visit went well.
27/06/19	Just the knowledge that it is there and it is happening.
05/07/19	None
16/08/19	No-I felt the visit was appropriate to the current needs and future development of the service.
20/08/19	No it was thorough and helpful
20/08/19	No
29/09/19	The visit was very good. Maybe having a clear and more structured reviewing time period.
04/10/19	No The visits are extremely supportive and helpful
14/10/19	None
20/11/19	Not right now.
20/11/19	no it was a very positive visit
20/11/19	Not really, perhaps more time to be able to show more of the work we do as it felt that there was still things we could of shared.
22/11/19	No suggestions I found the visit very helpful
18/12/19	maybe a have format that we can go through to prepare in advance
18/12/19	No, it is planned out well with topics needed to discuss
20/12/19	More time to be afforded for the visits. -For the QMT to research the service more ahead of visiting.
20/12/19	None its good as it is
31/12/19	No

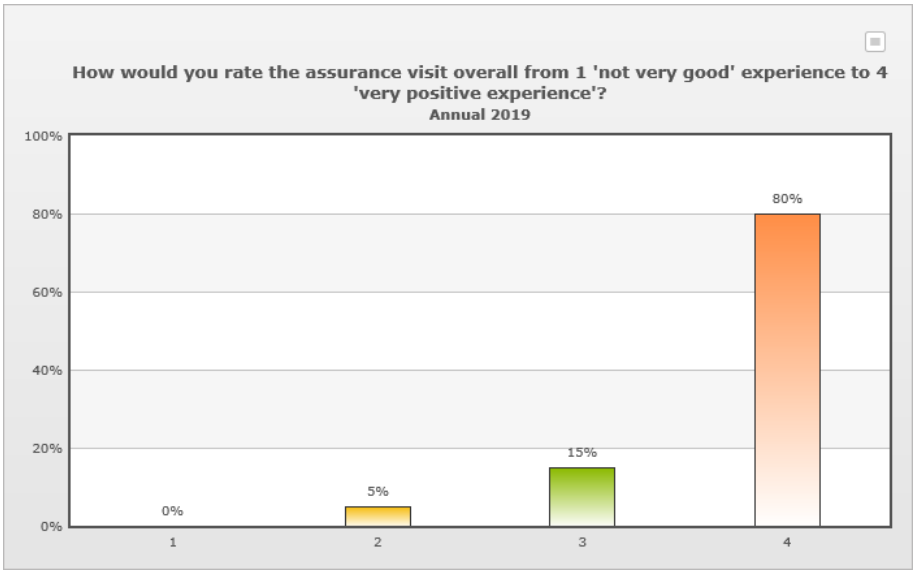
6. If you would like the opportunity to discuss this further please leave your details in the box provided below or get in contact with the person who completed the assurance visit

No responses

7. How would you rate the assurance visit overall from 1 'not very good' experience to 4 'very positive experience'?

Appendix 7

Quality Monitoring
Post Visit survey results Annual 2019



8. Do you have any other comments on the overall experience?

15/01/19	N/A
04/03/19	From the previous visit the clear format of the report I received supported me to work through the recommendations, and was easy to identify the area's of improvements, in line with CQC requirements.
24/06/19	None
27/06/19	Both were very approachable and listened and had helpful advice.
05/07/19	No response
16/08/19	All of the people who attended the visit were professional, polite, friendly and supportive
20/08/19	Thank you for your time and professionalism
20/08/19	No, it was
29/09/19	Was very good to meet and speak with the team.
04/10/19	A very helpful visit and very professional.
20/11/19	I thought it was very nice that you took interest in our work and were able to take out time to come and see us and one of our services. Thank you
20/11/19	Allison was very good and useful information exchanged
20/11/19	No
22/11/19	I gained a lot of knowledge from the visit especially with the suggestions that were given to myself, on how I can evidence things more that we are working towards achieving at Place Farm House.
18/12/19	really effective visit and good timely notes produced
20/12/19	Always nice to see Cassie.
31/12/19	Really appreciate the QA team to pay us a visit and give us impartial feedback on quality and progress we are making.

Appendix 8

Summary of latest published new approach ratings of active Social Care Organisations locations in Brighton and Hove

Figures taken from CQC data period January 2020 inspections completed to date

	Latest Rating	Number of Active Locations
1	Outstanding	4
2	Good	121
3	Requires Improvement	17
4	Inadequate	2
	Total	144

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 34 Brighton & Hove City Council

Subject:		**Sussex Health & Care Plan and the Brighton & Hove Plan: the Local Response to the NHS Long Term Plan**
Date of Meeting:		**18 March 2020**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report presents the Brighton & Hove Health & Care Plan (BHCP) for scrutiny. The BHCP is the local 'place' response to the NHS Long Term Plan (LTP). A copy of the Plan is included as **Appendix 2**.

1.2 The CCG slides (**Appendix 1**) outline the contents of the Plan and the Sussex-wide Sussex Health & Care Plan (SHCP). The SHCP is included at **Appendix 3**.

2. RECOMMENDATIONS:

2.1 That members note the contents of this report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The NHS Long Term Plan (LTP), published in 2019, sets out a blueprint for the development of NHS services across the next ten years. Regional NHS commissioners, providers and local authorities were asked to jointly develop their own strategic plans in response to the LTP. These were submitted for evaluation in November 2019, with definitive local plans agreed in early 2020.

3.2 The LTP requires health and care commissioners and providers to work together at three levels: operationally, in 'neighbourhoods' of 30-50,000 population; in 'places' of 250-500,000 people; and strategically, in 'systems' of 1-3 million people.

3.3 In local terms, the 'system' is Sussex and the Sussex Health & Care Plan (SHCP) sets out strategic planning for this area, including plans to develop a Sussex-wide Integrated Care System (ICS). Our local 'place' is Brighton & Hove; this is one of three 'places' within the Sussex system – West Sussex and East Sussex being the others. Each has its own development plan (e.g. the Brighton & Hove Health & Care Plan) which supports the delivery of the SHCP. There are

seven neighbourhoods in Brighton & Hove, sharing the same footprints as local Primary Care Networks.

3.4 Both the system and place strategic plans are by definition high-level documents. They will be supported by more detailed operational planning, including specific plans for service change where this is required by the strategic vision. Any NHS plans to make substantial variation or improvement to local services must be shared at an early stage with local HOSC(s).

3.5 HOSC members previously considered elements of the NHS LTP at the January 2020 HOSC meeting. Several members of the public also raised concerns about aspects of the LTP requirements at this meeting. The HOSC Chair has suggested that it would be sensible to consider these issues as a starting point when scrutinising the Brighton & Hove response to the NHS LTP. The issues raised at the January 2020 HOSC meeting include:

- Details of the local Integrated Care Partnership (i.e. the 'place' partnership of health and care commissioners and providers); particularly whether there are any plans to adopt a contract model with capitated funding for the local ICP.

- What plans are there to address the very low GP: patient ratios in Brighton & Hove?

- What plans are there to improve mental health services in Brighton & Hove?

- What are the plans to improve young people's mental health services in the city, particularly in terms of providing timely access to diagnosis and treatment?

- What are the plans to address local NHS workforce shortages, particularly in terms of medics and nurses working in acute settings and in mental health?

- What is going to be done to improve city acute healthcare performance in the short term, with particular reference to local under-performance against the national 18 week Referral to Treatment (RTT) targets for elective procedures and the national targets for cancer diagnosis and treatment?

- Does the establishment of a Sussex system 'footprint' mean that some patients will receive treatment further from home (e.g. at a Sussex hospital with spare capacity or with a particular specialism rather than at their local hospital)? If so, is there a commitment to ensure that there are affordable and sustainable transport options in place for both patients and family/carers before any changes are instituted?

- Governance issues; particularly the accountability of ICS/ICPs, now and going forward; and democratic accountability: e.g. the role of elected members.

- 'Neighbourhoods': e.g. whether these offer a genuine prospect of designing locally sensitive 'bespoke' services.

- Engagement and co-design of services with local people, particularly people from communities whose voice is typically not heard.

- What will the role of the private sector be in future health and care services?

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not relevant to this report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None directly.

6. CONCLUSION

6.1 Members are asked to note the area (Brighton & Hove) and system (Sussex) responses to the NHS Long Term Plan.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 Not relevant to this report for information

Legal Implications:

7.2 There are none to this report for information.

Lawyer Consulted: Elizabeth Culbert Date: 01/03/20

Equalities Implications:

7.3 At the January 2020 HOSC meeting members expressed interest in local planning in response to the LTP in relation to protected groups. This was specifically in terms of: engagement: e.g. how the NHS planned to engage 'hard to reach' communities on the plans; travel: how people from protected groups (e.g. older people/people with disabilities) would be supported to travel to and from healthcare appointments in a scenario where a more integrated Sussex health system may require people to access acute care from a hospital that is not local to them.

Sustainability Implications:

7.4 At the January 2020 HOSC meeting members expressed interest in the potential for additional patient journeys in a scenario where there is greater integration of acute healthcare across Sussex (e.g. where patients may be encouraged or required to travel to non-local hospitals where there is spare capacity or a particular specialism). In such a scenario, members were interested in what

support would be provided to ensure that people have access to sustainable and affordable travel options.

Brexit Implications:

7.5 None directly, although members may wish to explore the implications of Brexit in the context of the degree to which local health and care services are currently reliant upon an EU workforce.

Any Other Significant Implications:

Crime & Disorder Implications:

7.5 None identified.

Risk and Opportunity Management Implications:

7.6 None identified.

Public Health Implications:

7.7 Public health is integral to the place and system plans and is addressed at length in the plans.

Corporate / Citywide Implications:

7.8 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. slides on the local response to the NHS Long Term Plan – provided by Brighton & Hove CCG.

2. Brighton & Hove Health & Care Plan

3. Sussex Health & Care 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

Report for the Brighton & Hove Health Overview and Scrutiny Committee (HOSC)

March 2020

Contents

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

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**

Brighton & Hove response to the NHS Long Term Plan

NHS Brighton and Hove Clinical Commissioning Group

Brighton & Hove City Council

- ✓ Describes our collective vision for the Brighton & Hove system and outlines how, by working together, we can achieve the commitments set out in the Long Term Plan.
- ✓ Supports delivery of 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.
- ✓ Articulates the actions we will take to support improvements throughout the four stages of life, namely Starting Well, Living Well, Ageing Well and Dying Well.
- ✓ Sets out how, using improved partnership working amongst existing organisations and with communities, we will address the jointly agreed top local 4 health and care priorities for the city (Cancer, Mental Health, Multiple Long Term Conditions, Children and young people).
- ✓ Sets out that we will work collaboratively on prevention; integrating care through Primary Care Networks and improving the quality and provision of secondary care for long term conditions including cancer.

Partnership and collaboration	Individuals, communities and organisations across the city will work together to deliver our shared vision.
Health is everyone's business	Services and plans will reflect the contributions that factors such as education and learning, housing, employment, environment, leisure and culture, and transport make to improving health and wellbeing.
Health and work	Fulfilling work, including volunteering, contributes to good health and wellbeing – and local employers, communities and the economy will benefit from healthy workplaces and a healthy workforce.
Prevention and empowerment	Communities will be supported to develop networks and local solutions that lessen social isolation and improve wellbeing, and reduce the need for more specialist services. People will be encouraged and empowered to take responsibility for their health and wellbeing where they can. Early action will help people to live well for longer and to remain independent.
Reducing health inequalities	The physical and mental health of those with the poorest outcomes will improve the fastest. Services will be accessible to those who need them in all parts of the city, including people with learning and physical disabilities and those who are socially isolated.
The right care, in the right place, at the right time	Health and care services will provide high quality care, feel more joined up and will be delivered in the most appropriate place. Often, this will mean that more services are delivered in or close to people's homes.
Engagement and involvement	Local people of all ages will be active partners in the design, development and delivery of health and care services and supported to manage their health.
Keeping people safe	We want everyone to be safe from avoidable harm, taking particular care of our most vulnerable residents.

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 objectives for Brighton & Hove have we set out in the response to the NHS LTP?

NHS Brighton and Hove Clinical Commissioning Group

Brighton & Hove City Council

- ✓ Reduced health inequalities, with better health and care outcomes and a more positive experience for all residents.
- ✓ A strengths-based approach which maximises independence, self-care and utilises our local assets to contribute to health and wellbeing.
- ✓ A stable and healthy workforce able to operate in a multi-disciplinary approach, unhindered by organisational boundaries.
- ✓ Long term joint financial plan to underpin investment commitments into programmes such as prevention.
- ✓ Reduced demand on emergency and specialist health care, similarly and on residential and long term care.
- ✓ 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.
- ✓ Financial stability for health and adult social care within commissioning and provider organisations.
- ✓ Moving from shadow joint investment to truly pooled programme budgets with clearly defined outcomes.
- ✓ Provider market stability and collaborative working relationships with the community voluntary sector.
- ✓ A productive and influential partnership within the Sussex Health and Care Partnership (SHCP), shaping the strategic future of health and care provision to come.

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 avoid any unnecessary trips to hospital
- Continuing support for unpaid carers through Carers Hub, the Jointly 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 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

What is our ambition for partnership working in Brighton & Hove?

NHS Brighton and Hove Clinical Commissioning Group

Brighton & Hove City Council

1 To develop a shared vision and objectives, tailored to the needs of different neighbourhoods, aligned to the needs and wants of the population of Brighton & Hove and reflecting our Joint Health and Wellbeing Strategy and the strategic outcomes for improving health and care agreed by a wider group of partners across Sussex.

2 To set out how our priorities for the city as a whole and for neighbourhoods will be delivered through a plan which targets interventions at the most significant of health inequalities.

3 To deliver improved outcomes which matter to people, through collaboration between existing providers and commissioners of health and care and the communities which they serve and by building relationships between the NHS, the City Council, voluntary sector partners and community groups, and other public services supporting people across the wider determinants of health.

What activities will we need to support improved partnership working in Brighton & Hove?

NHS Brighton and Hove Clinical Commissioning Group

Brighton & Hove City Council

Collaborative planning…

We want to bring all partners across Brighton & Hove with an interest in improving the health of our population together to…

- Agree a shared vision for delivering better outcomes
- Confirm our priorities for the city as a whole
- Set priorities for each neighbourhood
- Set out a plan with clear timescales for addressing the most significant of our health inequalities, aligned to our Joint Health and Wellbeing Strategy

Commissioning for population health…

We want to embrace an approach which raises the value of strategic commissioning and establishes a unique role for commissioners across health and care in improving outcomes at a whole population level.

- Needs Assessment
- Segmentation
- Outcomes Development
- Contracting

Integrating care…

We want organisations from all sectors to work together with communities to model care delivery, integrate care, and address health inequalities.

Integrate Care & Address Health Inequalities
Co-ordination of self care activity, care planning & management, integration of care records, public & patient navigation, population education etc

Model Care Delivery
Develop operational plans, manage & plan demand & capacity, optimise whole system pathways, & allocate resources against delivery of contracted outcomes.

Manage & Evaluate Quality & Performance
Managing regulatory compliance of partners & services, safeguarding, system wide quality surveillance, and ensuring delivery of constitutional standards.

What are neighbourhoods and what will there role be in improving outcomes?

What are Primary Care Networks (PCNs) and what will they be doing?

NHS Brighton and Hove Clinical Commissioning Group

Brighton & Hove City Council

What are PCNs…?

A key building block of the NHS long-term plan in bringing general practices together to work at scale.

Focused on service delivery. Not commissioning bodies.

Funded from a directed enhanced services payment (DES), which is an extension of the core GP contract.

Will be the mechanism by which primary care representation is made stronger in integrated care systems.

Practices are accountable to their commissioner for the delivery of network services.

Since July 2019 Brighton & Hove has had 7 PCNs covering 35 practices across the city.

What will PCNs do…?

Will deliver a set of 7 national service specifications. 5 will start by April 2020 and the remaining 2 will start by 2021.

Provide a wider range of primary care services to patients, involving a wider set of staff roles than might be feasible in individual practices.

The footprint around which integrated community-based teams will develop to provide services to people with more complex needs.

Expected to think about the wider health of their population, taking a proactive approach to addressing health inequalities.

Responsibility for providing the enhanced access services, which pays GPs to give patients access to consultations outside core hours, will transfer to PCNs by April 2021.

Why are PCNs so important…?

Potential to benefit patients by offering improved access and extending the range of services available to them, and by helping to integrate primary care with wider health and community services.

Potential to strengthen resilience of primary care by improving the ability of practices to recruit and retain staff and to manage financial and estates pressures.

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

1. **Working together** as organisations enables the patients and the population to have a **seamless experience of health and care** where the most **appropriate care is provided most 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 will 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.

What is Sussex Health and Care Partnership?

Brighton and Hove Clinical Commissioning Group

Brighton & Hove City Council

SHCP is an aspiring integrated care system (ICS) aiming to provide a forum for leadership, strategic oversight and collective decision making in Sussex…

What is an ICS…?

A way for NHS and Local Authority partners to jointly give greater priority to the prevention of ill health by working together to tackle the wider determinants of health and wellbeing

Builds from existing partnerships to develop plans on how to improve health and care for the populations they serve

Provides organisations with the opportunity to think and act as part of a wider system to deliver faster improvements in care and shared performance goals

Supports a wider approach to establishing sustainability across health and care by providing a flexible finance framework within which to support transformation over the longer term

Creates the opportunity for effective collective decision-making around the wider determinants of care, aligned with accountabilities of constituent bodies, to maximise the opportunity for improving outcomes for populations.

Deploys rigorous and validated population health management capabilities to improve prevention, manage avoidable demand and reduce unwarranted variations

Planning for the future
Developing plans for improving health and wellbeing of populations

Managing performance
Overseeing performance, setting local standards and monitoring progress towards achieving shared goals.

Optimising our acute care services
Standardise clinical practice; make better use of clinical support services; & more creatively and flexibly use the skills of staff.

Owning and resolving system challenges
Encouraging partner organisations and associates to come together to create solutions by working together as a system

Integrating regulation
Over time, develop "self-assurance" for the Sussex health and care system.

Providing system leadership
Supporting a shift to a focus on places and populations and with providers taking more responsibility for shaping services and improving quality of care.

The Sussex Health and Care Partnership and local accountability

- The ICS offers a framework for NHS organisations and Councils across Sussex to work more effectively as partners. The statutory obligations and accountabilities of existing organisations are not changed as a consequence of the ICS being established.

- It does offer an opportunity for the NHS in Sussex to undertake "self-assurance" rather than this being undertaken by NHS England and NHS Improvement. Plans for this have been set out to NHS England and NHS Improvement and will need to be approved prior to "self-assurance" being delivered in Sussex and prior to the ICS assuming any further regulatory powers.

- It's important to note that local government's regulatory and statutory arrangements are separate from those of the NHS. Whilst we will look to establish mutual accountability arrangements for the work to be undertaken by partners across Sussex certain aspects of these will not apply to councils because of the differential regulatory arrangements. For example, Councils would not be subject a single NHS financial control total and its associated arrangements for managing financial risk. The ICS offers the NHS and councils the opportunity to align planning, investment and performance improvement only where it makes sense to do so.

- **Democratically elected councillors will continue to hold partner organisations accountable through their formal Scrutiny powers.**

APPENDIX 1

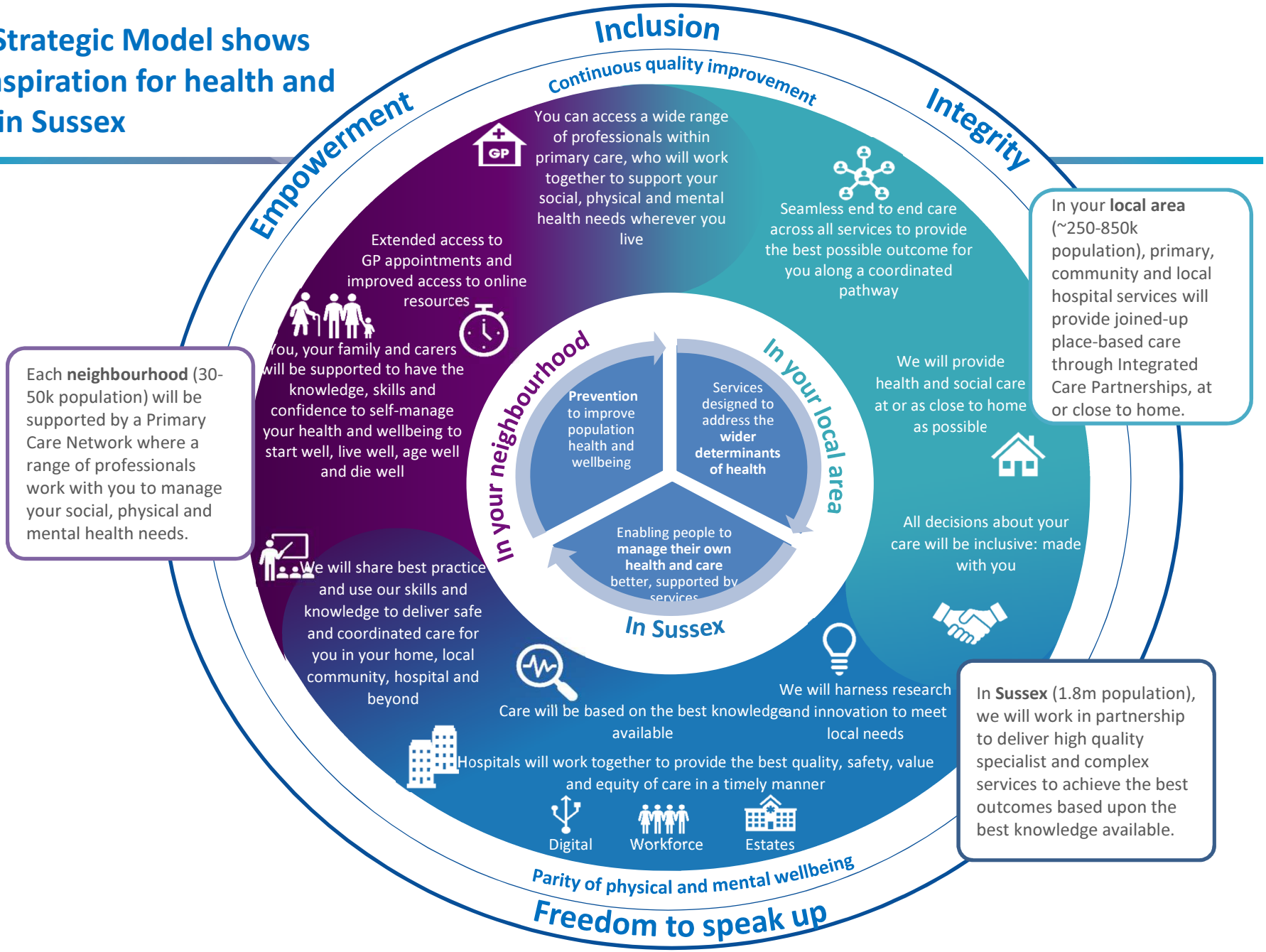
STRATEGIC MODEL FOR HEALTH AND CARE IN SUSSEX

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

SUMMARY OF HEALTH AND CARE STRATEGIC PLAN INTENT

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

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.

APPENDIX 2

SUPPLEMENTARY EXTRACTS

- PLANS TO IMPROVE PERFORMANCE

- PLANS TO ADDRESS INEQUALITIES

- SUPPORT FOR PRIMARY CARE IN THE CITY

Plans to improve local performance

Transforming out of hospital and community-based care

- Integrating physical and mental health services . This will include a new approach to mental health training for all professionals working in our services. For example building on successful multidisciplinary work in Primary Care Networks across the City.
- Giving people more control over their own health and more personalised care – information based shared decision making
- Effecting digital transformation of primary care and outpatients
- Support self-management and empower patients e.g. shared decision making
- Continue to build on the work with community voluntary sector, for example developing social prescribing and other community asset based approaches

Reducing pressures on urgent and emergency care

- Integrating urgent care with a 'digital front door' enabling effective care navigation, the ability to book an appointment at the appropriate service. This will include appointments at GP practices, primary care improved access hubs and other community services, and for urgent access.
- Improved responsive services delivered in the community
- Improved crisis response and reablement
- Enhanced care in care homes

How the Plans address inequalities

An Equality and Health Inequalities Impact Assessment has been developed and considered:

- The assessment shows that the plans will positively impact on most protected characteristic groups, and help to reduce health inequalities across Brighton and Hove, as it underpins development and transformation of all local health care services with a focus on improving access, integration, prevention and self-care and education for the whole of the City's population.

Specific groups who will be positively impacted upon by the Brighton and Hove LTP response are:

- Older people; Children and young people; Disabled people; LGBTQ+ ; Trans; BME groups; Pregnant people; Men; Women; Carers and Homeless people

Priorities in Brighton and Hove will be older people, children and young people, pregnant people, and disabled people, as outlined in the four 'well' programmes.

Other aspects of the plans regarding addressing inequalities include:

- An engagement plan that links in voluntary and community groups, and families and schools that are involved and will be engaged with.
- Building on the links with voluntary and community organisations and groups who work with and support minority groups.
- Specific Community Voluntary Groups will be targeted to work with us and to help us
- Continued work with local authority and public health teams to establish data collection sets and monitor protected characteristic, health care access and patient feedback
- Staff engagement events, for example NHS Staff Equality Network.

Support measures for primary care in Brighton

The GPFV, published in 2016, laid the foundation for change in General Practice. It aims to better utilise the talents of the wider workforce; maximise the potential of digital technologies; encourage working at scale across practices to shape capacity; and extend access to General Practice including evening and weekend appointments. These were reinforced by the publication of the NHS Long Term Plan (LTP) in 2019.

Primary Care Networks (PCNs) offer an opportunity to relieve pressure on individual practices by working together at scale. For example, the development of Multi-disciplinary Teams (MDTs) of GPs, Community Services, Mental Health, and BHCC Adult Social Care to provide targeted interventions to patients with complex needs; and the employment of new Social Prescribing staff in each area of the city will help patients access more readily the care that they need.

The development of the Workforce. We want to make Brighton an attractive place to work through promoting new ways of working, attracting locums into accepting salaried posts in General Practice; and supporting practices in the development of new, purpose build premises. For example, we have been working with BHCC to site new GP premises in the Preston Barracks development, and funded feasibility studies for practices to consider new sites on which to offer their services.

Improving Practice resilience. High Patient:Doctor ratios, an increasingly elderly population, and a rising workload all threaten the continued delivery of GP services. The CCG regularly assesses the resilience of all practices and works proactively with them to ensure they remain as robust and responsive to the changing health and social care environment as possible. This can be through funding training, commissioning support for practice nurses in smaller practices who do not experience the benefits of a larger team; funding new Locally Commissioned Services which ensure practices are remunerated for work they undertake; and offering a platform for practices to offer online consultations (to go live in 2020/2021) not to replace face to face appointments, but as an additional resource for patients that want them.

APPENDIX 3

PUBLIC INVOLVEMENT

Brighton and Hove Long Term Plan

Public Involvement

Background:
Big Health and Care Conversation

- Held 2017/18
- Over 6,500 people took part in discussions
- Range of methods- survey, events, engagement pop ups, targeted outreach
- Included work with young people: You and Your NHS

- Themes collated and final report produced

Background:
Our Health and Care, Our Future

- January – May 2019
- Based on the NHS Long Term Plan and the Surrey and Sussex Population Health Check

Phase 1 Engagement: High level thematic

- Keynotes events in key locations – one in Central Brighton
- Online survey
- Outreach and networking events

- Across Sussex, over 750 people engaged face to face
- 130 responded to an online survey

Phase 2 Engagement: targeted/general

Across Sussex, over 1,500 people engaged, focussing on communities and people not reached in phase 1

Area	Date	Number of Attendees (Approx)	Population Focus	Engagement Type
Brighton and Hove	2 April 2019	40	Ethnic Minority	BAME event – Healthcare
	25 May 2019	30	General Public	Open Market
	5 June 2019	20	Ethnic minority	Gujarati Cultural Society
	21 June 2019	9	Young people	Brighton, Hove and Sussex Sixth Form College
	18 July 2019	30-40	People with a learning disability	What's out there event for people with learning disabilities?

Engaging with our marginalised groups

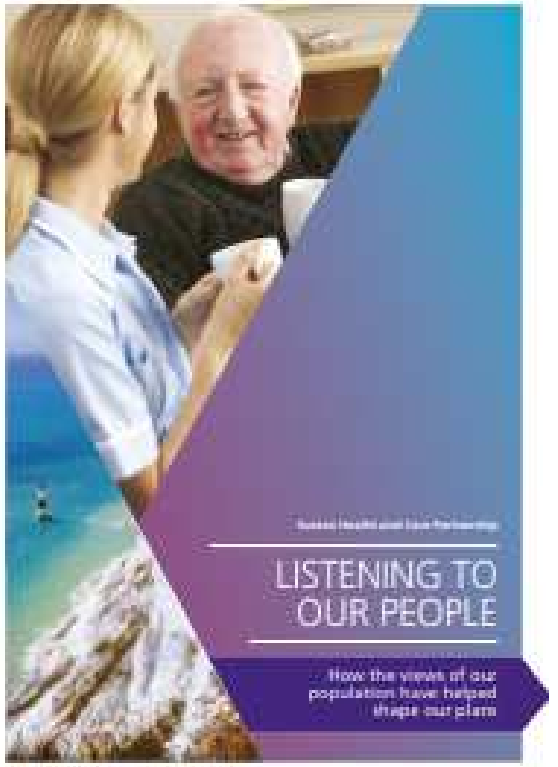
Commissioned engagement, focussing on LTP priorities, with:

- Age UK – **older people** who are isolated
- Amaze/Carers Centre- **parent carers/carers**
- YMCA Downslink Group - **Young people**
- Possability People – **disabled people**
- Mind – **people living with mental health issues**
- Trust for Developing Communities/Hangleton and Knoll project– **BAME people**
- Friends, Families and Travellers – **Gypsies, Roma and Travellers**
- Switchboard – **LGBTQ people**

The above and past intelligence informed the EHIA for the B&H LTP response

Report “Listening to our People”

Summarises key feedback and how it has shaped the Long Term Plan response for Sussex and our places.



Future engagement

- **Cascade and comment:** Upon publication, the local plan will be publicised through key stakeholders and our usual channels, with invitations to comment or to express interest in getting involved in key work areas
- **Bespoke Communications and Engagement plans** to be developed for key work streams within local plan, to include:
  - Involvement objectives
  - EHIA and inclusion involvement objectives
  - Impact monitoring
- **Feedback mechanisms** to be enhanced, ensuring our people know that their input has had an impact
- **Developing partnership approaches** to engaging with some of our more marginalised groups- e.g. homeless, substance abuse, Trans, pockets of BAME communities
- **Supporting asset based working** with our community groups and Primary Care Networks
- **Public Consultation** where significant change proposed
- Use of new **online engagement platform** to co ordinate engagement activity and collation of feedback (across Sussex)

“Business as usual” engagement

- **Ongoing partnership approach** between CCG and Local Authority

  Aligned working, particularly related to integration

- Establishing **B&H Communications and Engagement Network**, across:

- Statutory sector – NHS and LA (including providers)
- VCSE
- Healthwatch
- Public Members (Community Ambassadors)

to co ordinate and align communications and engagement approaches and map experience across pathways to better understand “journeys”

Ongoing engagement

- Continuation of **building our networks**:
  - Patient groups
  - VCSE organisations
  - Community/neighbourhood groups and forums
  - Partners including Fire and Rescue services, Sussex Police
  - Community Ambassadors
  - Health Network

- Continuation of **Inclusion Engagement** – local and pan Sussex approaches; informing our EHIAS and work to reduce health inequalities

- Expand use of **digital engagement** methods

- Improved **triangulation of intelligence** across partners and joint impact measuring across “health and care journeys”

Sussex Health and Care Partnership

Brighton & Hove

PLACE-BASED RESPONSE TO THE LONG TERM PLAN

VERSION B – NOVEMBER 2019

Delivering the NHS response as part of our Joint Health and Wellbeing Vision for our Population

Contents

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 (LTP) 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.

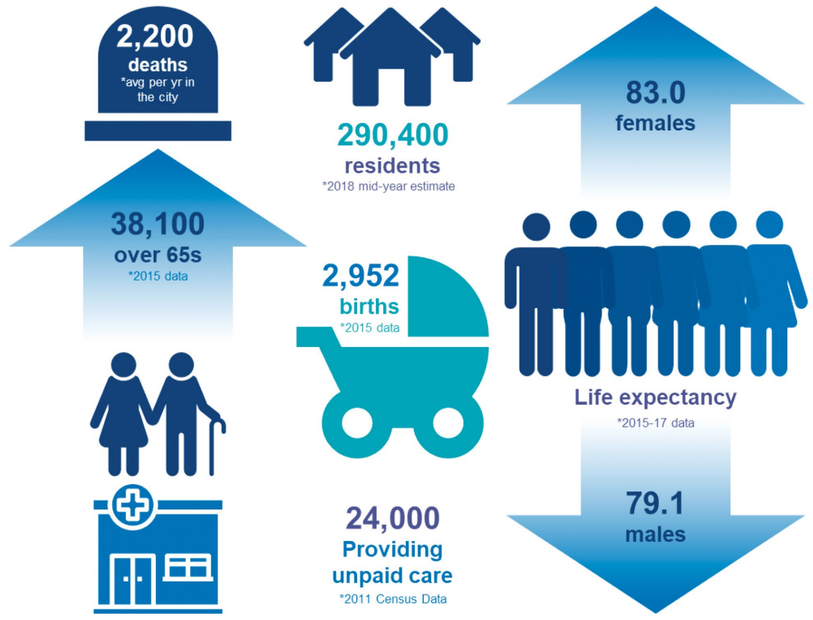


Figure 1: *Our population*

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.

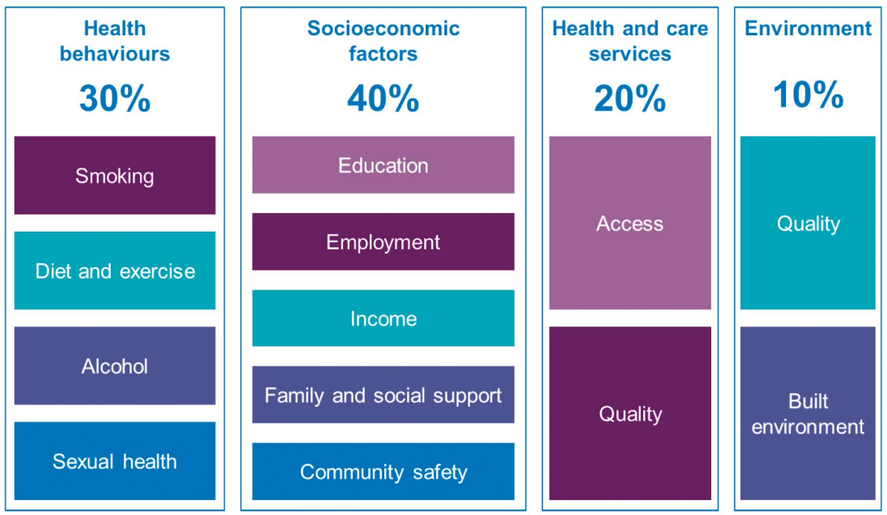


Figure 2: *Wider determinants of health; Source: County Health Rankings Model 2014*

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

Housing and homelessness

11% (14,600 people) estimated to be in **fuel poverty** (2016) (11% England)

Those on the lowest 25% of earnings need **12 times their earnings** to afford the lowest 25% of house prices (2018)

64 rough sleepers (Street count 2018)

Air pollution

5.8% of adult mortality (30+) is attributable to particulate air pollution (2017)

Road safety

56 per 100,000 people killed or seriously injured on the roads in the city (2015-2017) (41 in England)

Community safety

37 per 100,000 people admitted to hospital due to violent crime (incl. sexual assault) (2015/16 to 2017/18) (43 England)

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)

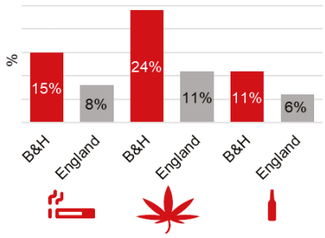
6% smoking at delivery 11% England (2017/18)

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

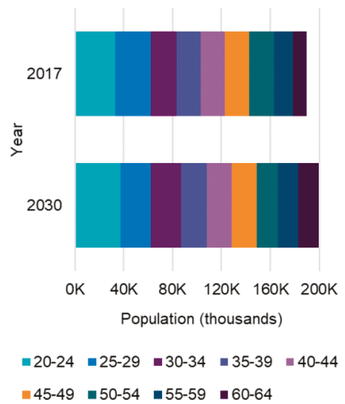
10% say that they often / sometimes hurt or harm themselves (2018)

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

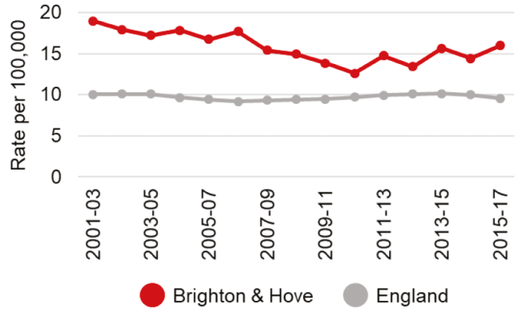
77% of adults are physically active and 16% inactive (2017/18)

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

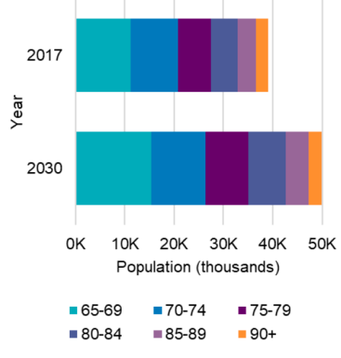
Screening rates for breast, cervical and bowel cancer are all lower than England

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.

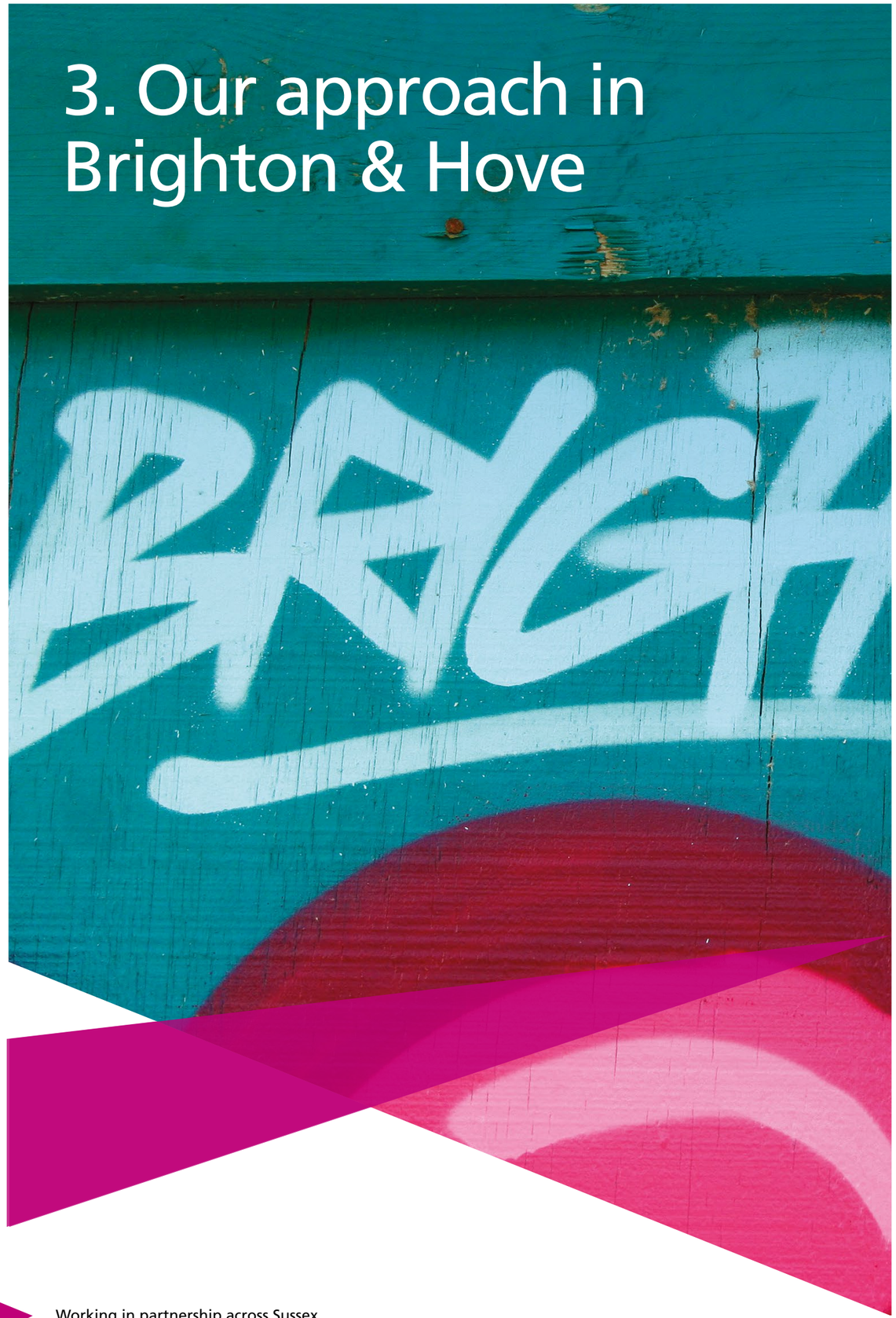
Despite the system's positive ratings one area that has been particularly challenging has been in urgent care and specifically the performance of the Emergency Departments (A&E) at Brighton and Sussex University Hospitals NHS Trust (BSUH).

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.

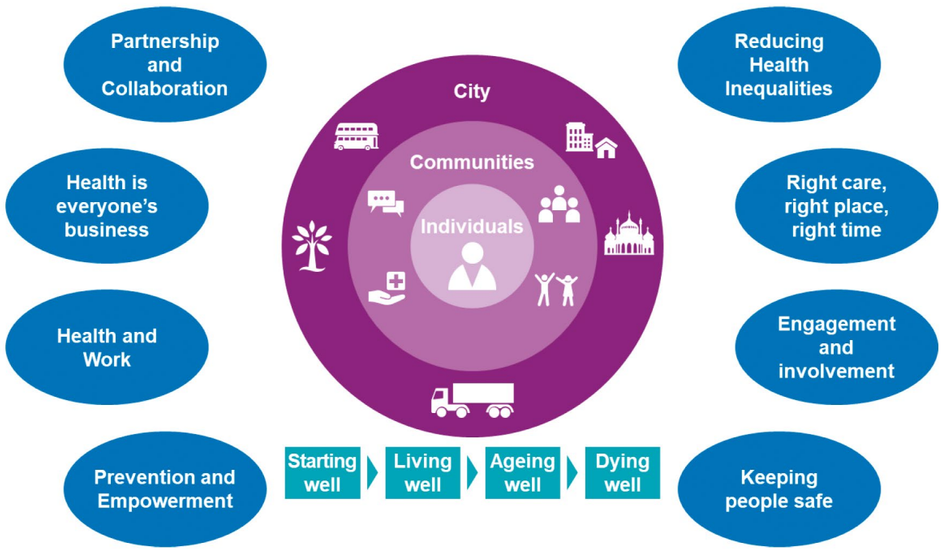


Figure 3: *Our Health and Wellbeing Vision*

3.2 OUR SYSTEM PRIORITIES

Through a process of reviewing evidence, data and intelligence with strong clinical input, as well as feedback from patients and the public, the top local 4 health and care priorities for the city were jointly agreed as follows:

- Cancer
- Mental Health
- Multiple Long Term Conditions (including frailty and dementia)
- Children and young people health and wellbeing

In order to address these health and care priorities for the city and working across the 4 wells we will work collaboratively on the following system priorities:

1. **Prevention:** prioritising, investing and integrating primary, secondary and tertiary prevention across care pathways. Enabling self-care and self- management of conditions targeting effort to those requiring it most and providing social prescribing and community and voluntary sector support is part of this as well as support for smoking cessation, increasing physical activity, weight management, substance misuse and alcohol support services.
2. **Development of integrated and joined up care through Primary Care Networks** working with community health, secondary/acute, mental health, social care, public health and community and voluntary sector providers. This includes meetings the funding guarantees for primary medical and community health services as well as doing things differently, delivering personalised care, supporting the role of carers and digitally enabling care.
3. **Improving quality and provision of secondary care for long term conditions** including cancer.

3.3 OUR APPROACHES TO UNDERPIN OUR COLLABORATIVE SYSTEM

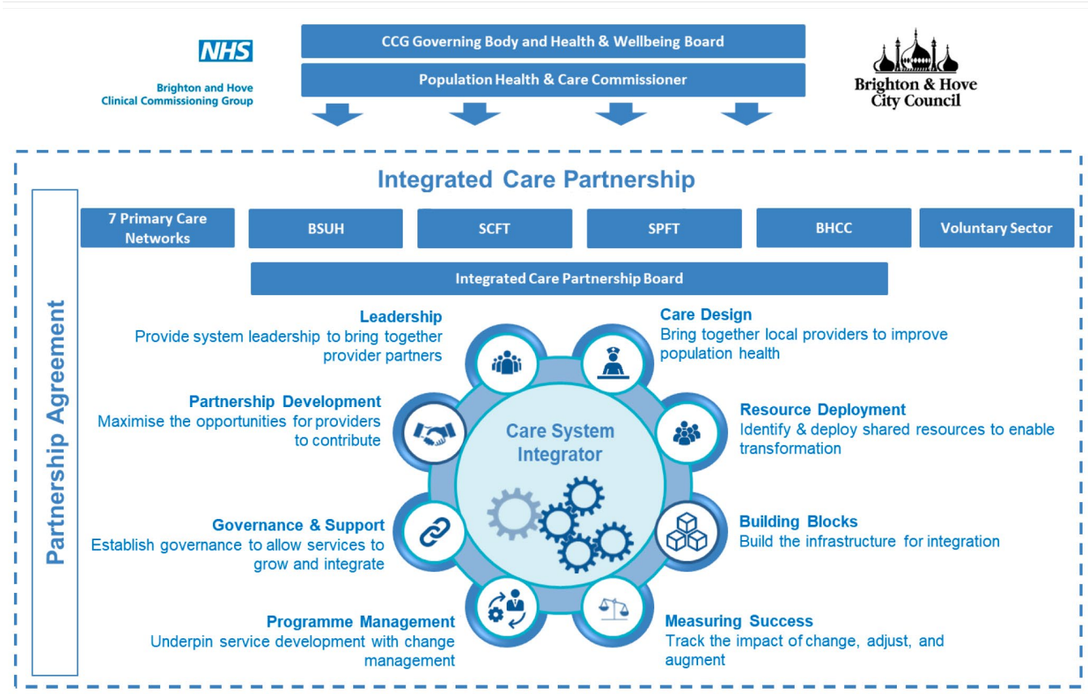
The findings from the Joint Strategic Needs Assessment, additional population data analyses, and engagement feedback, were brought together in a series of workshops to inform a set of approaches to be adopted as we move into our new collaborative system and deliver our plans:

- 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.
- Proportionate universalism will be applied as part of commissioning and in contracts with providers, so that universal services are provided but with greater resource to those that need it most with the aim of reducing inequalities in health. In addition we will increase monitoring of protected characteristics and integrate conducting health equity audits as part of the commissioning cycle for commissioned services.
- 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.

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.



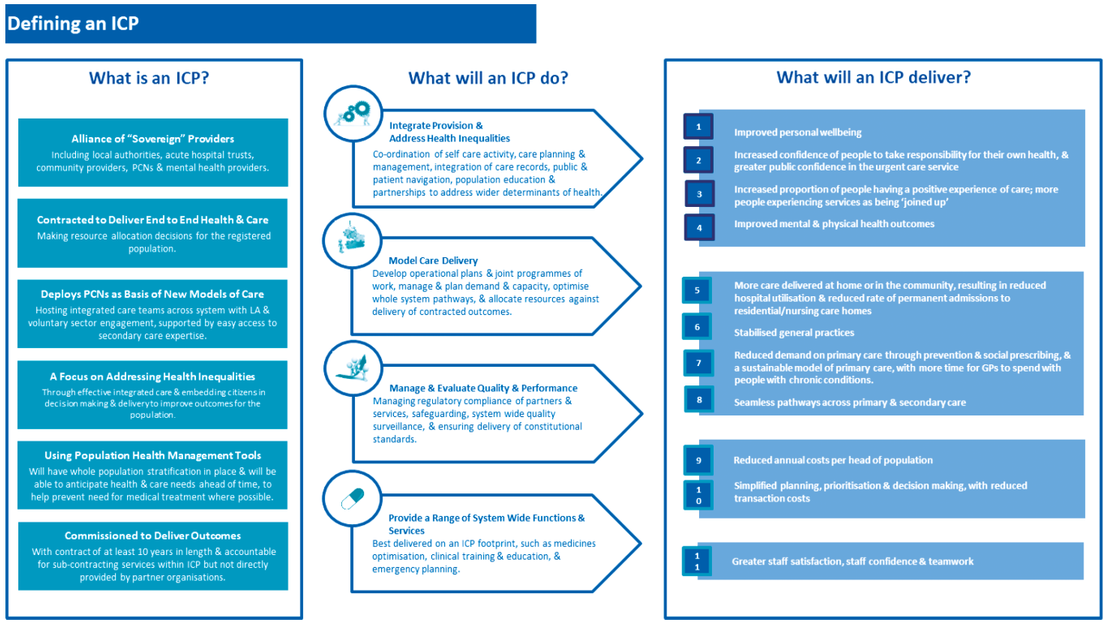


Figure 3: *Defining an ICP*

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 LTP 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

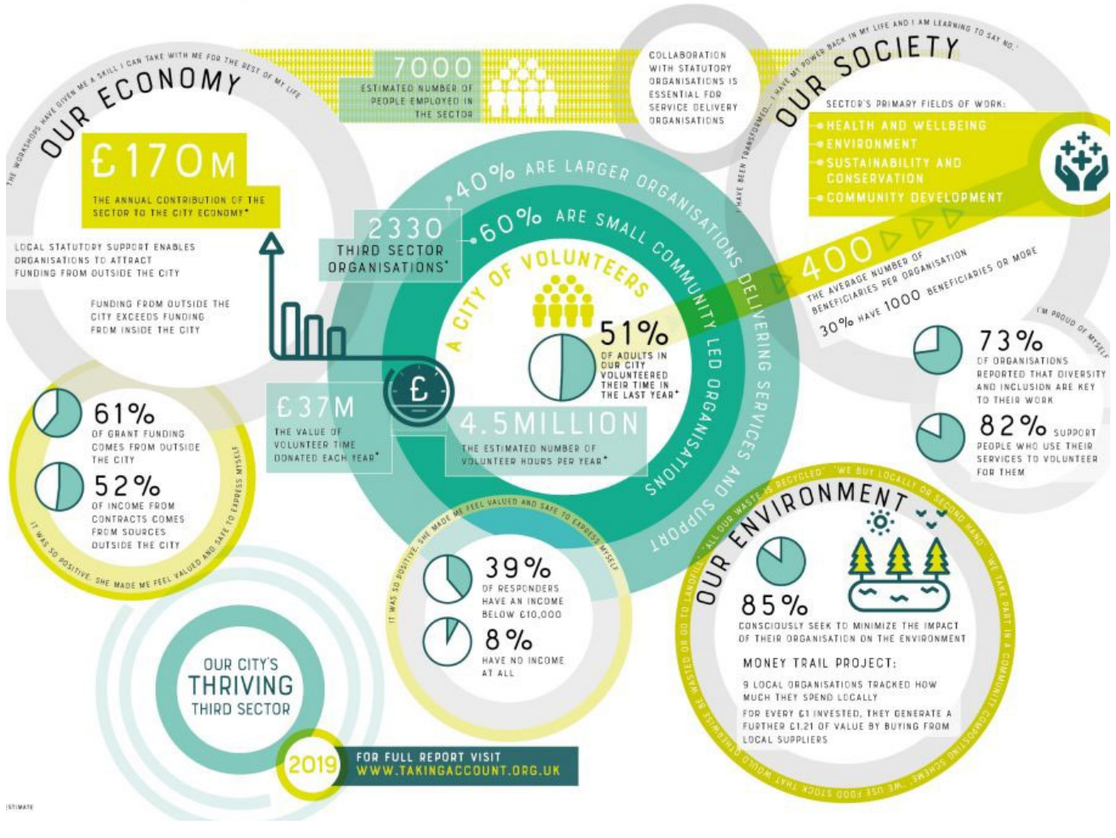


Figure 4: *Assets in Brighton & Hove*

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

The evidence base clearly identifies that events that occur in early life (indeed in foetal life) affect health and wellbeing in later life. Whether this is through changes in genetic expression, how the brain is formed or emotional development, we increasingly understand that what happens in these years lays down the building blocks for the future… Therefore, to try to impact on the diseases of adult life that make up the greatest burden of disease, it makes sense to intervene early (Chief Medical Officer, Report 2012).

In Brighton and Hove we want all of our children and young people to have the best possible start in life, so that they grow up happy, healthy and safe with the opportunity to fulfil their own potential (Commissioning Strategy: Health and Wellbeing of Children, Young people and families 2015-20).

Our Health and Wellbeing Strategy sets out our priorities for the improvement of services for children and young people (CYP) with a focus on early years so that we maintain our good breastfeeding rates and improve the uptake of childhood immunisation and promote healthy lifestyles and resilience through high quality, accessible and joined-up services. A whole family approach will be promoted and, where appropriate, services will intervene early to provide support to prevent problems escalating.

Other key initiatives supporting our delivery are:

- Sussex and East Surrey Local Maternity System Transformation Plan– set up to improve services and support for pregnant women, babies and their families
- Sussex-Wide Children and Young People's Emotional Wellbeing Services Review – due early 2020
- Joint Strategy with the Local Authority for children and young people with special Education Needs and Disabilities (SEND) – due January 2020

We now need to ensure delivery of NHS LTP commitments for children and young people fit with and complement all of the above strategies and with increased emphasis on greater partnership working as the new integrated care system landscape starts to take shape.

For Maternity and Neonatal Care, we will have a specific focus with system partners across Sussex on:

- Providing extra support and safer, more personalised maternity and neonatal care as captured in the LMS Transformation Plan (see Section 7.4.1 of the Sussex Strategic Delivery Plan)

For Children and Young People, we will have a specific focus with system partners across Sussex on:

- Developing age-appropriate integrated care
- Integrating physical and mental health services
- Enabling joint working between primary, community and acute services,
- Supporting transition to adult services
- Improving care for children with long-term conditions, such as asthma, epilepsy, diabetes, and complex needs;
- Improving waiting times for autism diagnosis and providing the right care for children with a learning disability (See Section 7.4.3 of the Sussex Strategic Delivery Plan)
- Treating and managing childhood obesity (See Section 4.2.1)
- Childhood screening and immunisations and other public health functions (See Section 6.3.4 of the Sussex Strategic Delivery Plan)

- Supporting the expansion of Children and Young People's mental health services
- Improving outcomes for children and young people with cancer (in conjunction with Sussex-wide cancer work)
- Improving palliative and end of life care
- Increasing personalisation (See Section 4.2.5)

This will be delivered through our emerging place based operating model and will be underpinned by: clear clinical and management leadership, co-production with children, young people, families and carers; and bringing together local leaders from across the NHS, local government, education and other partners. Some of the above will sit within other parts of our local delivery plans and teams.

4.1.1 INTEGRATING CHILDREN'S AND YOUNG PEOPLE'S SERVICES

A programme of work has been implemented over the last five years to integrate a multi- disciplined approach to children and families under the care of The Royal Alexandra Childrens' Hospital. This includes psychological support for children with long term conditions and more recently a team to work with children with complex symptoms including Chronic Fatigue Syndrome. The next stage of this work is to streamline the delivery model through a single contract and ensure a sustainable model with the right capacity in the right place going forward.

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 Child Development Centres and CAMHS with the increase in neurodevelopmental conditions in children and young people. A 3 year phased programme of investment is already in place for an integrated neurodevelopmental pathway to provide a more coherent and integrated service with a single point of entry.

4.1.2 TRANSITION TO ADULT SERVICES

Work has also been undertaken to scope the commissioning and service gaps and barriers for transition from paediatric services for young people with complex health and special needs. We now need to consider the opportunities for PCNs and the role of primary care to support these young people. 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. A business case will be developed with key partners, including young people and families to articulate a service model to meet the identified gaps and needs.

4.1.3 PALLIATIVE AND END OF LIFE CARE FOR CHILDREN AND YOUNG PEOPLE

Recognising the need to invest and improve these services in line with the LTP, priority work is being taken forward with partners across Sussex to map and benchmark our services against the following:

- Personalised Care and Advance Care Planning
- Specialist palliative care MDT services
- 24/7 access to palliative and end of life care support and advice
- Palliative and end of life care education and training
- Palliative and end of life care services including
- Support for people in their own home or preferred place of care

A costed service improvement plan will enable us to consider the option of matched funding from NHS England in 2020.

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 LTP commitments for children and young people's mental health are met, including Improved Access to Psychological Therapies (IAPT), new models of care, Family Eating Disorder Service, Crisis Response Service, Substance Misuse Services, and workforce development initiatives.

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

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

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

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

Maternity and Neonatal Services

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;

Our public health partners through the Healthy child Programme are also working on significant areas to support the best start in life including:

- 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.

In recognition of our current starting point in Brighton and Hove there will be a particular focus on personalisation and choice, in order to provide women with a choice of three options for intra-partum care: home birth, obstetric-led pathway or midwife-led pathway of care. There is potential for

a midwife-led unit 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; 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 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.

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
Katherine Johnson, Planned Care Lead Commissioning Manager, B&H CCG –October 2019

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).

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

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

"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

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

Urgent and emergency care

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, and urgent treatment centres (UTCs). 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.

Our work is underpinned by our Adult Social Care Target Operating Model focusing 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.

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.

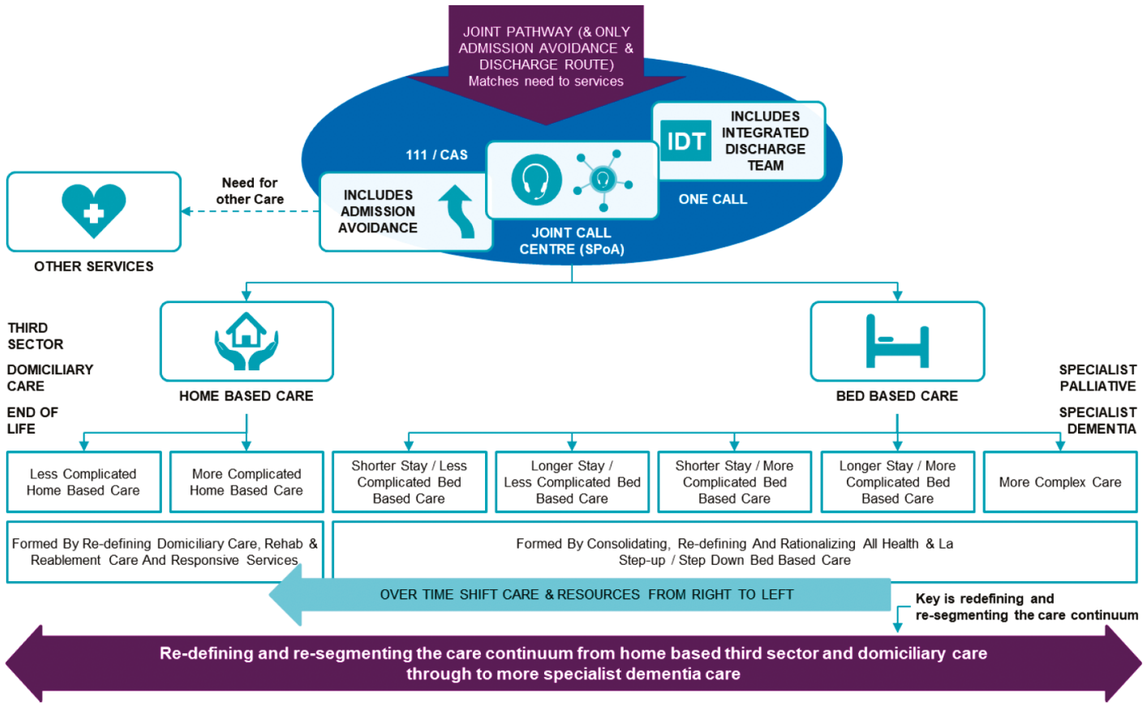


Figure 5: *New model of bed-based care*

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.

6.4 COMMUNICATIONS AND ENGAGEMENT

6.4.1 HOW HEARING FROM OUR POPULATION HAS SHAPED OUR LOCAL PLAN

Brighton and Hove has a history of strong engagement with local people, groups and communities, with Healthwatch and our vibrant Voluntary and Community Sector. We have had a range of approaches to engagement, working jointly with the Local Authority in many cases in order to maximise our reach.

We established a successful, wide reaching, engagement programme in 2017/18- the Big Health and Care Conversation, during which time we had many conversations with local people, groups and stakeholders about plans for our key areas of health and care services. This intelligence has helped shape our local work and has contributed to how we have developed and shaped our Brighton and Hove response to the NHS Long Term Plan.

6.4.2 DEVELOPING OUR BRIGHTON AND HOVE PLAN – INSIGHTS AND KEY THEMES FROM RECENT ENGAGEMENT

In early 2019, the "Our Health and Care, Our Future" engagement programme was held across Sussex; phase one sought high level feedback on key themes within the Long Term Plan, and key areas pertinent to the different geographical areas across Sussex and Surrey. This engagement programme built on the Big Health and Care Conversation, exploring themes, and working to understand what local people need and prioritise.

Phase 2 of the Our Health and Care, our Future focussed on local communities, many of whom were not engaged in phase 1, and/or who have the greatest health inequalities.

Through our commissioned programme of equalities engagement, we heard from local groups that work with or support these communities, about aspects of the Long Term Plan that are important to them.

Additionally, Healthwatch were commissioned by NHS England to support the NHS in the engagement work of the Long Term Plan.

Themes from the above engagement have helped shape our Brighton and Hove Plan, and will continue to be used as we explore areas of service in more depth, and transform services.

We will use these themes to inform the development of a local Outcomes Framework, based on what is important to local people about their health and care, and which will be jointly owned and shared across the health and care system.

6.4.3 KEY THEMES FROM ENGAGEMENT SYSTEM WIDE AND IN BRIGHTON AND HOVE

The city is diverse and has pockets of communities that have high health inequalities, such as Transgender people, BAME communities and people who are geographically and socially isolated. Our engagement with local people in the Big Health and Care Conversation (2017/18), "Our Health and Care, our Future" engagement programme (2019) and our commissioned engagement with some of the city's equalities communities raised the issues below, which have helped shape and influence our local plan, and will further help develop our action plans for key areas of work.

Engagement with our communities is ongoing, and we will continue to seek views, hear from our communities and act on feedback as we progress our local plans.

System change and transformation

There was general acceptance of the challenges faced by the NHS and the need to change, including pressures on health services and workforce related issues; there was an agreement that the needs of the population have changed significantly since the NHS was initially established, and the system needs to transform and adapt to reflect the changing needs.

People felt that commissioning of services needs to be fair and respond to local need, not just a way to save money. There is a lack of understanding of how the NHS 'system'

works, and a need for simple and coherent information. Any changes need to be communicated in a number of formats so that it is accessible to all.

Joined up care, services and partnership working

People told us there needs to be better co-ordination between the different parts of the heath system, and between health and social care. Having to repeat a "story", health issues and wider concerns of a number of individuals in different services is not acceptable in an age where we are able to share information digitally. People often require support from many different services so the public sector also needs to collaborate with services such as housing, transport and the community and voluntary sectors. Also, there needs to be better communication and co-ordination between planning and provision, ensuring that infrastructure is in place to respond to, for example, planned housing developments.

It was felt that discharge from hospital is a key area where joined up care needs to improve; people were aware of the pressures on hospital capacity, but flagged up that unless the care system is effective and working closely with the health system, not only would there be delays in discharge, but the needs of the individual may be compromised. Partnership working is key to improving this, and the importance of working with the city's vibrant voluntary and community sector was emphasised.

Primary Care

In general there was support for the development of the concept of "Health Hubs", which align to Primary Care Networks, although there was concern that this would affect people being able to see "their doctor" or go to their own practice. There was appreciation of the workforce challenge facing primary care, and concern about attracting GPs and nurses to the area.

Concern was expressed strongly about ongoing access to primary care, given that there have been a number of closures of GP practices in the city over recent years. People reflected concern that they would lose "their" practice and need to travel elsewhere, and that this would burden an already stretched primary care system. People understood that you don't always need to see your named GP or even a GP at all (people would be happy to see a nurse or specialist) but seeing a named GP would benefit some groups (such as LGBT, people with multiple long term conditions or disabilities).

Social Prescribing

There was general support for the concept of social prescribing; it was felt that, in a time where health and care services are under pressure, there are assets in communities, local VCS and other groups that can provide support.

People with learning disabilities told us that making sure self referrals, referrals from adult social care and referrals from Voluntary and Community Sector organisations are included in the offer to help reduce some of the barriers they would have in accessing social prescribing. Often they are not given information to support their wellbeing in GP surgeries.

People with disabilities welcomed social prescribing because they told us it can be difficult to maintain a healthy lifestyle and weight especially if they have mobility issues and many do not know about low cost or free services they can access.

Prevention and self-management

There was agreement that prevention plays a key role in the sustainability of services. People told us that they think important prevention messages should be given at an early age in schools, and that communities could play a key part in ensuring prevention messaging and activity is supported. NHS Health Checks were also highlighted as an opportunity to talk to people about lifestyle and behavioural changes.

People felt that self-management should be encouraged, and that individuals should be taking more responsibility for their own health and wellbeing; however, it was emphasised that people need the right information and access to health and other professionals when needed. It was recognised that behaviour change and making lifestyle changes can be challenging particularly for people where there is also a mental health issue.

Digital

There was positive feedback about the use of digital services and innovations such as Online GP consultations, but it was strongly fed back that it should be remembered that this does not suit everyone, and there are some groups – such as people with learning disabilities and some older people – that would still need access to a face to face service, and reassurance that this will still be available. It was suggested that there was more use of digital technology to provide reminders for appointments.

It was felt that NHS systems need to be co ordinated, so health records are available whether you are accessing services in the community or hospital.

Waiting for hospital care

There was concern over waiting times for referral for hospital care, and about the communication relating to appointments. People told us that often they are not given accurate information on waiting times, and not offered a choice of provider.

Urgent Care

There remains a general lack of knowledge about urgent care options and knowing what service to access for different ailments. People did not understand the terminology and struggled to differentiate between urgent and emergency care. People reflected a lack of confidence in NHS 111, and little knowledge of GP Improved Access appointments.

However, there was awareness of the pressures on A&E departments (the media was referenced frequently as a source) and a willingness to consider other options when explained.

Mental Health and Wellbeing

When we asked people about what's important to them, mental health (and prevention) was consistently an area where people thought the resources needed to be prioritised.

There were concerns expressed about Mental Health services in Brighton and Hove; the issue of waiting times for care was raised and the lack of services for those with acute needs. It was seen as positive that "the Haven" at Mill View hospital had been opened, but there was concern about its ongoing capacity.

Young people and parent carers raised concerns about the waiting times and scarce resources for Child and Adolescent Mental Health services, and the need for focus to reduce this and to improve the transition between child and adult MH services.

Satisfaction with services is particularly poor for people with Special Educational Needs and Disability (SEND).

Our BAME communities reflected that in some cultures, because there is still a taboo around mental health, they are reluctant to seek support.

Feedback from our equalities groups and communities

We commissioned VCS groups in Brighton and Hove to undertake engagement with some of our most marginalised groups and communities, which means we have a rich source of intelligence about need and experience. Many of the issues raised by these groups are included in the above; however there are other community specific issues, which will be highlighted and addressed through embedding Equality and Health Inequality Impact Assessment in all our service transformation work.

6.4.4 TESTING THE EMERGING PLANS

During January – March 2020, we will be engaging with local people about the areas set out in the plan, the benefits they will bring and to help inform any changes and improvements to how services will work in the future. We will use existing and new system-wide processes and structures which will give greater focus to partnership working. We will continue to hear from reach and hear from people on our various areas of work, ensuring that their views and experiences influence and shape our ongoing integration and transformation work.

An Equality and Health Inequality Impact Assessment (EHIA) is being developed to support the Brighton and Hove plan, to ensure recognition of potential impacts on our community members and to consider ways to mitigate such impacts. This EHIA will be used as the baseline impact assessment for specific commissioning projects and initiatives.

We will continue to reach and hear from local people on the various areas of work, ensuring that their views and experiences influence and shape our ongoing transformation and integration work.

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
- Social Value Framework
- Community Collaboration Framework

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

Published 20 March 2020
All information correct at time of printing

Sussex Health and Care Partnership

Our health and Care OUR LOCAL LONG TERM PLAN

HOW WE WILL IMPROVE HEALTH AND CARE FOR OUR POPULATIONS

Responding to what our people want

Over the last few years we have spoken with thousands of people living across Sussex about health and care services. Every individual has a different view, experience and story to tell but there are some things that everyone wants:

- Our people want to be supported to live a healthier life.
- Our people want to be able to look after themselves better if they do become ill or, if they can't do that, they want to be able to see the most appropriate expert as soon as possible at a time that is convenient for them.
- Our people want to know what services are available to them and want to get the care and treatment they need as quickly and easily as possible.
- Our people want to have as few appointments as possible and ideally want to get the best care close to where they live, or at home if possible.
- Our people want and expect health and care organisations to work in a joined-up way so their care and treatment is seamless from start to finish.

To be able to give our people what they want, we need to change how health and care services work

Our health and care organisations across Sussex have been working hard over the years to try to give our people what they want and rightly expect from health and care services. However, we have not always been able to do this for a number of reasons.

People are now living longer thanks largely to advances and improvements in health and care and, although this is positive for us all, many people are not in good health as they get older and some spend years needing constant treatment and care. This means more people are using health and care services more often. The problem is we only have a limited number of beds, staff and resources available to meet this growing demand. Additionally, some services work differently to one another, do not always work in a joined up way, and use outdated technology and buildings that are not fit for modern day health and care.

As a result, we face challenges around the growing demand for health and care which means services are often under extreme pressure, causing some people having to wait longer than they would want to get the care they need. It also means that the cost of paying for services has been increasing and, although the amount of money we have to spend for them is also increasing, we still do not have enough money to pay for all the services that our people currently need to use.

To be able to give our people what they want, we need to change how health and care services work and we now have an opportunity to do so with the Sussex Health and Care Plan.

This plan sets out our vision for how we want health and care services to better support our populations over the next five years and ensure our people are getting more of what they want and need in future. It represents our system-wide response to the local health and care needs of our populations and the national ambitions and expectations set out in the NHS Long Term Plan.

Responding to what our people need

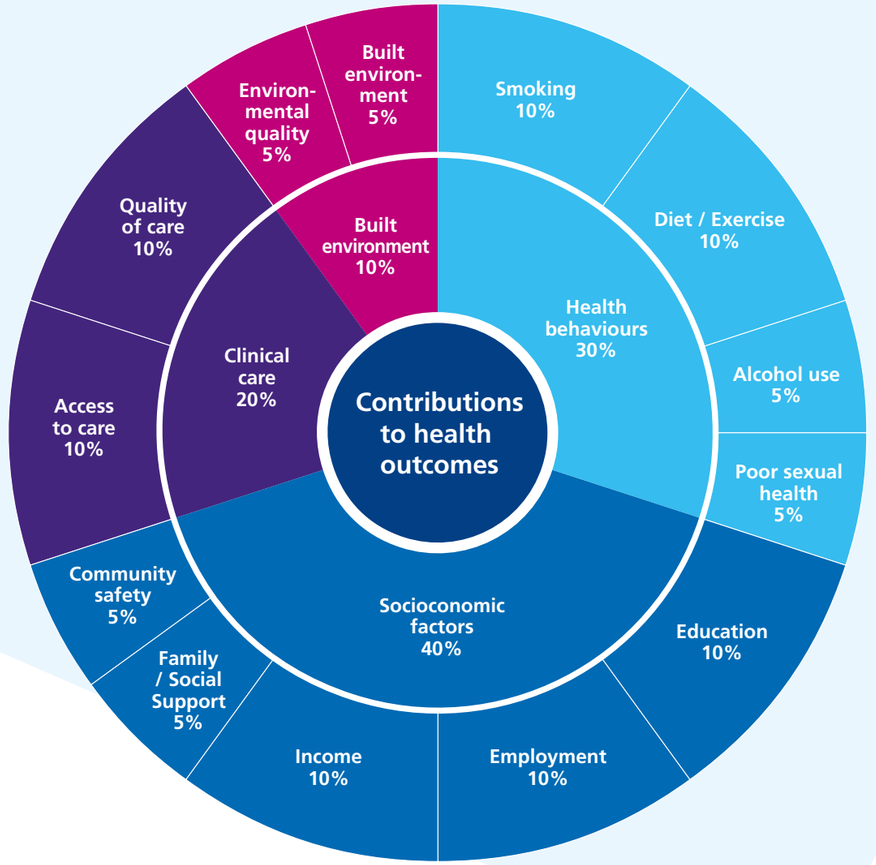
The health and care needs of our populations are constantly changing. The way we all live our lives in constantly changing. So it is essential that local health and care services also constantly change to give our people the care they need in a way that better suits their busy lives.

Research into what contributes to someone's health shows that only around 20% is influenced by clinical care, with the other 80% relating to other factors, such as education, health behaviours, employment and the environment. Many of these factors are not within the responsibility of the NHS and social care services and are influenced by other organisations, particularly local authorities. So it is clear that these organisations need to work together if we are to best support all the health needs of our populations.

Looking at the population of Sussex, we know that the poorest and most deprived people are more likely to be in poor health, have a lower life expectancy and have a long term condition or disability. Some groups, such as Black, Asian and minority ethnic (BAME), LGBT+, people with special educational needs and disabilities, people with long-term mental health problems and carers, may require more intensive support and additional help to access services.

We know that the resident population across Sussex is predicted to increase by the year 2030, with the largest growth coming in people over-85 group, which is expected to increase between 32.5% and 42.1%. This will put extra demand and pressure on health and care services in future.

To help us develop a plan to better meet the needs of our populations, we have used clinical evidence from our 'Population Health Check'. This was published in January 2019 by local doctors, specialists and professionals from across our region and represented a diagnosis of the current health of our people and the areas we need to improve.



They used data and information provided in the local Joint Strategic Needs Assessments of West Sussex, East Sussex and Brighton and Hove, and found that 75% of deaths and disabilities across our local area 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 services.

Additionally, it has been identified that the four unhealthy behaviours of smoking, alcohol misuse, poor diet and low physical activity, along with social isolation and poor emotional and mental wellbeing, are responsible for at least a third of ill health.

This clinical evidence has been used as the foundation for our plans and ensures the we design future services in a way that better meets the needs of our people.

The resident population across Sussex is predicted to increase by the year 2030 with the largest growth coming in people over-85 group

Our population in numbers

Children and young people

2x national average

We have more children and young people smoking at the age of 15 than the national average – Brighton & Hove is double the national average with 15%.

15% Year 6 pupils are obese

15% of our year six pupils are obese and there are higher rates in deprived areas.

We have higher rates of hospital admissions for self-harm of children and young people aged 10-24 compared with rest of England, particularly in Brighton and Hove and Hastings.

Adults

Smokers on GP registers

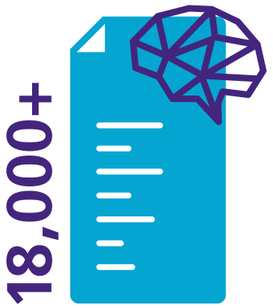
We have 250,000 smokers on GP registers, with high rates in Brighton & Hove and Hastings.

adults with depression

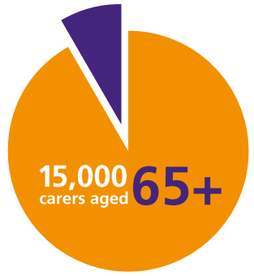
We have over 155,000 adults with depression on GP registers, which is 10% of patients.

Physical activity rates vary across the area, with 78% in Brighton & Hove and 27% in Eastbourne.

Older people



We have over 18,000 people on the dementia register and many more are not diagnosed.



of 183,000

We have over 183,000 carers, with 15,000 carers aged 65 and over.

110k

We have over 110,000 older people who live alone.

Dying well

50.7% of our population die in their usual residence but this is only 37.2% in Crawley.

Our ambition for the future

Our ambition is to create a health and care system that will improve more lives, extend more lives and save more lives of people living across Sussex.

We will do this by developing new ways of working that focus on helping people stay healthy for longer, giving them greater support to manage their own health when they do become ill and making sure that those who need help get the right care, in the right place at the right time more often.

We want to support all aspects of people's lives that contribute to their health and wellbeing and develop teams from across organisations that work together to give greater joined-up care that is right for the individual. We want to have 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.

Our specific aims are to:

- Strengthen the role of prevention from birth and the need to address all the factors that contribute to someone's 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 manage and protect their own health, and engage in treatment and 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.

Our principles

We have a number of principles which underpin our plans for the future:

Delivery health and care differently

- **Less need to travel:** We know people prefer to have their care delivered close to home where possible. Information should flow between service 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 the first time leads to quick, safe and efficient advice or treatment.
- **Timely provision:** Services should be delivered in a timely way that also manages demand and expectations.
- **Ensure appropriate movement of people across the system:** When people move across service providers, it should only happen where necessary and should be managed effectively.

To tackle inequalities, we must give more intensive support to those who are at greatest risk of poor health and may need additional help to access services.

Organise health and care differently

- **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 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 organisational and departmental boundaries and create greater end-to-end care.
- **Incentivise quality outcomes:** We should plan and buy services based on the outcomes we want for people and measure this against a diverse set of metrics agreed with our populations.
- **Maximise quality through reducing variation:** We should maximise quality by targeting the efficient delivery of high value, evidence-based care.
- **Digital compatibility:** Digital solutions should be developed in ways that make information sharing possible across organisations.
- **Partnership working:** Health and social care working in partnership across Sussex will deliver the best quality and safety of care in a joined-up way.

How we will achieve our ambition

Integration and collaboration

No one organisation currently supports, manages and influences all the factors that affects someone's health. Instead, a person usually requires help and care from a number of different organisations, departments and teams to meet their health and care needs. It is, therefore, essential that the NHS, local authorities and other partners responsible for providing care for our populations work closer together to give people the best possible experience when they need treatment, support and care.

This will be done by increasing the joined-up, or 'integrated', working and collaboration of health and care organisations in future.

What we mean by integration:

- We want the NHS and local authorities to work closer together to be able to plan and pay for ("commission") health and care services. This will reduce the fragmentation that people experience in our current healthcare system and allow services to work in a way that is more joined-up and better address health inequalities.
- We want organisations that provide services to work closely together to benefit local people. In particular, we want close and effective working between primary and urgent care, community and mental health services, social care and the voluntary sector, to ensure individuals receive the best possible care.
- We want to develop 'Integrated Care Teams' that are made up of professionals and experts from a number of organisations and areas working together for our populations.

A new 'model' of health and care

We have developed a clinically-led Health and Care Model, which sets out our new way of organising and delivering services. The model has three building blocks – prevention, services that address the factors that contribute to someone's health, and enabling people to manage their own health and care.

These building blocks will be at the centre of our approach to designing health and care services, and will include:

- Engaging the population 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 services.
- Providing access to advice and support for the whole population to keep themselves well.
- Increasing the use of social prescribing to enable individual solutions for people, 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.

We want the NHS and local authorities to work closer together to be able to plan and pay for ("commission") health and care services.

Responding to our people's priorities:

Greater focus on prevention

During 2019 we travelled across Sussex speaking to members of the public and asked them what areas they felt we should prioritise in the future. A top priority identified was prevention and this is an area that we have given particular focus on as part of our plans for the future.

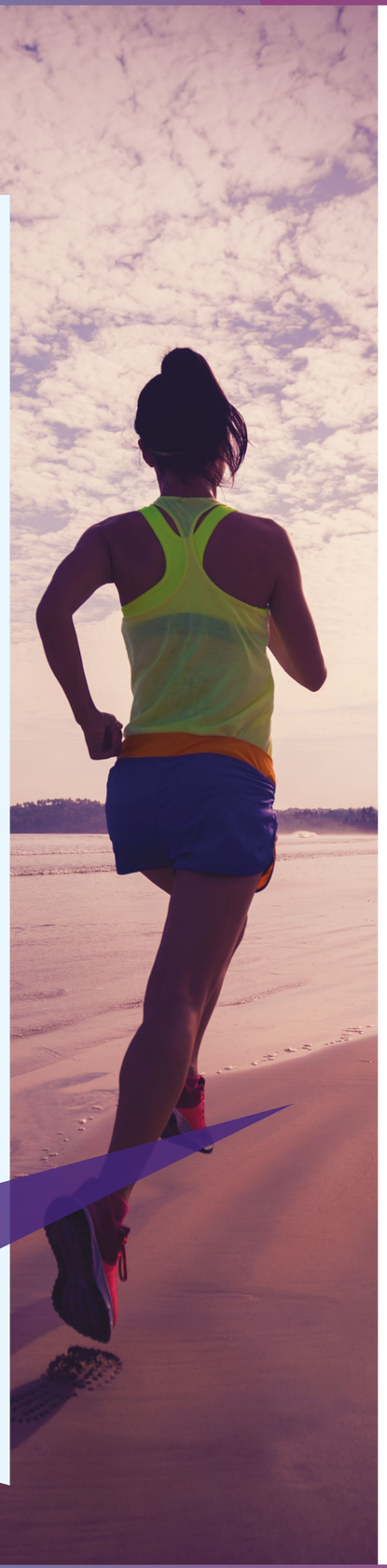
Prevention is one of the central building blocks of our strategic model and is, therefore, the responsibility of our whole system. We know that a number of different factors are important in preventing ill health, which is why we are considering housing, work environment, employment, and education alongside health and social care.

For 2019/20, our key priorities for Sussex are:

- To establish the role of the NHS and key partner organisations as anchor institutions to influence all the factors that influence someone's health.
- Promoting a culture shift that makes prevention everyone's responsibility.
- Developing a healthy workplace programme to improve the health and wellbeing of working people.

Over the next five years, we are committed to:

- Supporting a good start in life, including promoting a healthy weight, and good emotional wellbeing.
- 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 and improving health outcomes for those long-term conditions.
- Supporting our population to age well by promoting both physical and mental wellbeing.



The three levels of health and care

The new model is based on health and care being delivered at three levels – neighbourhood, local area and Sussex.

Your neighbourhood

We will plan and design local services that better meet your needs across your local neighbourhood, which will typically be around a population size of 50,000 people. This might be your town or your local community.

HOW IT WILL WORK

- Each neighbourhood will be supported by a Primary Care Network (PCN), which will involve GP practices working with local community services, mental health, social care, pharmacy and voluntary sector teams to provide integrated health and care for local people.
- Each neighbourhood will be supported by the equivalent of 10-18 additional staff by 2023/24 through the new GP contract.
- 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 teams to take responsibility for these needs.
- PCN teams will be supported by easy access to and partnership with local hospices and specific secondary care expertise.

BENEFITS TO LOCAL PEOPLE

By planning, designing and delivering services at a neighbourhood level, we will be able to give greater focus on:

- Identifying, preventing and treating health and care issues at an earlier stage.
- Meeting the health and care needs of the individual person.
- Supporting early cancer diagnosis.
- Enhancing health in care homes.
- Preventing and diagnosing cardiovascular disease.
- Tackling neighbourhood health inequalities.
- Reducing variation in how health and care is given.
- Providing more services outside of working hours.
- Home visiting.
- Social prescribing.
- Supporting and giving advice to people for common mental health conditions.
- Palliative and end of life care.

Your local area

Health and care organisations will be working together as partnerships in future to provide care for the different populations of West Sussex, East Sussex and Brighton & Hove. These will be referred to as 'Integrated Care Partnerships' (ICPs) and will enable primary, community and local hospital services to provide greater joined-up care.

HOW IT WILL WORK

- We will redesign services around a person's needs so 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 will be made up of existing providers, including Local Authorities, acute hospital trusts, community services and other providers within a Primary Care Network, that deliver end-to-end healthcare. This will involve providing all the care someone needs, allocating resources and addressing local health inequalities.
- Integrated Care Partnerships 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 unjustified differences in outcomes for people. This will be undertaken in close collaboration with the public.
- The partnerships will lead to integrated care teams, whose composition will depend on the need of the specific local area and the outcomes that matter to that population.

BENEFITS TO LOCAL PEOPLE

By providing services at a local area level through Integrated Care Partnerships, we will be able to give greater focus on:

- Tailoring services better to meet local needs.
- Organising community health and care services locally, including rapid response teams, rehabilitation and other proactive approaches.
- Managing local provision of musculoskeletal, cardiovascular and falls/fragility services to reduce unjustified differences in care outcomes, specifically in those areas identified in the Population Health Check.
- Providing a range of functions across the local area, such as the management of medicines, clinical training and education, emergency planning, effective use of technology, and palliative care.
- Managing demand in urgent care.

Across Sussex

All health and care organisations across Sussex will work in closer partnership to deliver and plan specialist and complex services to improve the outcomes of our populations and reduce health inequalities.

HOW IT WILL WORK

- Complex services will be planned and managed collectively across Sussex for our population.
- Our health and care professionals will work together to deliver the best and safest care to enable our population to start well, live well, age well, and die well.
- There will be support for the PCNs to manage our population's needs on a larger scale through advice and guidance for inter-acting with more specialist services and county-wide approaches.
- 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.
- Providing clinical leadership across the region through clinical networks.
- Working in a consistent and co-ordinated way across urgent care.
- Better managing lower volume specialist services, including major trauma, plastics and burns, hyper-acute stroke, neonatal and specialist paediatric care, neurosciences, cardiac surgery and specialist cardiology, renal services, and specialist rehabilitation.
- Co-ordinating and setting strategy across clinical services, such as mental health provision and the local maternity system, to ensure high quality services across Sussex and support research and education.
- Developing specialist centres 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.
- Digital compatibility across the system to 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.

BENEFITS TO LOCAL PEOPLE

Working as a Sussex-wide system will help us give greater focus on:

How this will benefit our people

In parts of Sussex, health and care organisations and services are already working in a more joined-up way and this is bringing tangible benefits to local people. The examples below are three of many that illustrate the improvements we are making to people's lives and highlight how we increasingly want to be working in future.

GIVING BARBARA THE RIGHT CARE, IN THE RIGHT PLACE, AT THE RIGHT TIME

Barbara suffers from Parkinson's Disease, which has a serious impact on her mobility, meaning she suffers from regular falls. After a recent fall, paramedics attended her house and advised that Barbara should be taken into hospital. Neither Barbara nor her husband wanted this to happen, so the Crisis Response service was called. This service involves an integrated team of nurse practitioners, healthcare assistants, occupational therapists, physiotherapists and night sitters. It aims to help people who are unwell and who may previously been admitted to hospital to stay at home. This allows them to be cared for in a familiar environment without the added stress and anxiety of being admitted to hospital.

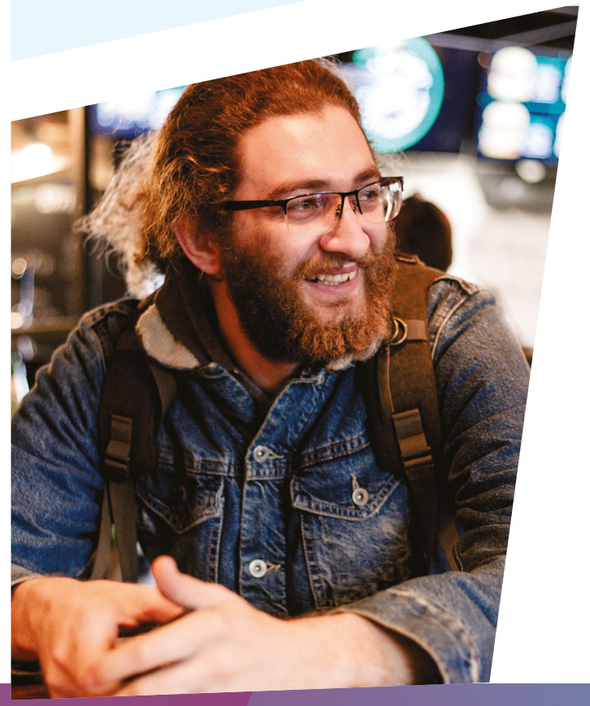
The team put together a care plan that gave immediate support to Barbara and her husband and then did a further assessment so that the right support was arranged to enable her to remain safely in her own home afterwards. We now want more people to receive the care they need closer to home.

USING RESOURCES EFFECTIVELY TO HELP MARTIN GET THE CARE HE NEEDS

Martin, 23, called his doctor's surgery to ask for an appointment because he had been suffering from anxiety. The receptionist he spoke to had been specially trained to signpost Martin to the most appropriate service for his need. She asked him if he had heard about an NHS service providing courses and other types of therapies that help with stress, anxiety and low mood. She explained that by completing an online form he could refer himself to the service, without the need for a GP appointment.

After submitted his form, Martin was contacted by a member of the service team for an initial appointment and then took part in a free course near to where he lives in Sussex, which has helped him cope with his anxiety. By using the service, Martin has got the care he needs and has saved the NHS money and the clinical time that would have been spent on his appointment had he seen a GP.

We now want to invest more of our time, expertise and money to help people like Martin get the right care, the first time. To do this we need to change how we use the limited resources available and make decisions that will help us get more out of the money we spend.



GIVING JOE EQUAL ACCESS TO THE SERVICES HE NEEDS

Joe has been homeless for three years. Life on the streets has taken its toll on his physical and mental health but accessing health and care services can be difficult for vulnerable and disadvantaged people like him. Luckily for Joe, a weekly multi-agency hub was launched in his part of Sussex to improve access to services and support for rough sleepers and the street community. Different agencies are available to give advice and sign-post him to services and information on issues including housing, mental health and drug and alcohol treatment. He is also able to take a shower and wash his clothes while he is there.

Through visiting the hub, Joe has been able to register with a local GP practice and has made links with adult social care and a local housing officer to look at his options for the future. We now want everyone to be able to access health and care services no matter what their background or circumstances.

Responding to our people's priorities:

Greater focus on mental health

During 2019 we travelled across Sussex speaking to members of the public and asked them what areas they felt we should prioritise in the future. A top priority identified was mental health and this is an area we have given particular focus on as part of our plans for the future.

Our aim is that, by 2025, all people with mental health problems in Sussex will have access to high quality, evidenced-based care and treatment delivered by accessible services that are well connected with the wider community, and that intervene as early as possible in someone's life to prevent mental ill health.

We are increasing our investment in mental health by £50.5m over the next five years as well as additional funding to deliver specific commitments. This has allowed us to develop clear and detailed plans for mental health services which are owned by the whole healthcare system to ensure specific local needs are addressed and Sussex-wide policies are tailored for maximum impact.

We are developing a prevention strategy that has strong links between mental and physical health and we aim to provide services that are fully inclusive of people who need additional support, including those with learning difficulty or autism.

How we developed the plan

Our Sussex Health and Care Plan sets out how we are responding to the local health and care needs of our populations and the ambitions of the NHS Long Term Plan.

The NHS Long Term Plan was published in January 2019 and set out the national expectations for the NHS over the next five to ten years. The Long Term Plan outlined a significant number of objectives and systems across the country were asked to develop by November 2019 how they were going to deliver it locally.

Our Sussex Health and Care Plan represents a collective effort across our partners and has been formally agreed through our statutory organisations.

In developing our plan, we have built on work that has already taken place over the last few years to improve and join-up health and care services. This has already involved partners from across NHS organisations, local authorities, the community and voluntary sector and patient groups working closer together to focus on giving our people improved care.

Our plan has been developed with the involvement and input of partners, clinicians, specialists, health and care professionals, staff, and our public. It has been led by our Clinical and Professional Cabinet, which is made up of local doctors, clinicians and professionals from across Sussex.

We carried out a significant amount of public engagement to inform the plan, with around 1,500 conversations taking place across Sussex. This was done through a combination of engagement events, focus groups and online surveys. This included members of the public, patients, carers, people experiencing mental health problems, physical and sensory disabilities, people from diverse ethnic backgrounds, former members of the UK Armed Forces.

As well as having a plan for Sussex, we have developed three supporting locally-focused plans across West Sussex, East Sussex and Brighton and Hove which describe how the system-wide plan will be delivered. These local plans build on the collaborative working and local transformation plans that were already in place and are linked to the local Joint Strategic Needs Assessment, Health and Wellbeing Strategies and the significant amount of public engagement that has taken place across our local areas over the last few years.

The resident population across Sussex is predicted to increase by the year 2030 with the largest growth coming in people over-85 group

Sussex Health and Care Partnership

Published 20 March 2020
All information correct at time of printing

Item	Description	Referred By	Notes
HOSC Items 2020/21			
15 JULY 2020 HOSC			
Establishment of a Joint HOSC (JHOSC)	BH HOSC is required to join a JHOSC to scrutinise NHS SViS plans that cut across HOSC boundaries	HOSC has legal duty to consult with NHS re: SViS plans	BH HOSC rejected (Jan 19) proposals to join a voluntary JHOSC, but will be required to join a mandatory JHOSC if and when NHS bodies announce cross-boundary SViS plans (e.g. re: CEC tranche 3) NB: HOSC will need to approve plans for JHOSC, but FC is final BHCC decision-maker
Clinically Effective Commissioning (tranche 3)	CEC is Sussex-wide programme to standardise commissioning and ensure it aligns with best clinical practice	Anticipated referral by CCG (summer 19?) HOSC has legal duty to consult with NHS re: SViS plans	CCGs have indicated that they anticipate that CEC tranche 3 will include cross-border SViS and will consequently require scrutiny by a joint HOSC (JHOSC) of B&H, East Sussex and West Sussex HOSCs. Although this will be for a JHOSC rather than HOSC, HOSC will need to determine how it wants to be updated. **Contacts:**

			Peter Kottlar, Wendy Hughes, Raheem Anwar (CCGs) Helena Cox (West Sussex HASC) Harvey Winder (East Sussex HOSC)
Royal Sussex County Hospital (RSCH): Improving Outpatient Services	BSUH plans to improve OP services	HOSC has legal duty to scrutinise local NHS performance	CQC rates OP services as requires improvement. Improvement planning discussed at March 19 HOSC – HOSC to follow-up and monitor improvement trajectory? **Contacts:** Oliver Phillips (BSUH) Ben Stevens (BSUH) Jayne Black (BSUH)
Cancer	Monitor local performance re: screening (bowel, cervical, breast) and treatment	HOSC HOSC has legal duty to scrutinise local NHS performance	CQC identifies local cancer performance as a concern and BH performance re: screening and re: treatment is poor. Report at March 19 HOSC – HOSC follow-up/monitoring? **Contacts:** Becky Woodiwiss (BHCC PH) Max Kammerling (NHS England) Ben Stevens/Oliver Phillips/Jayne Black (BSUH)

			Lola Banjoko/Dr Alex Mancey-Barratt) CCG
Healthwatch Report on Older Patient Experience of Discharge from RSCH	Monitor implementation of report action plan	Healthwatch BH HOSC has legal duty to scrutinise local NHS performance	At March 19 HOSC members considered HW report on hospital discharge and agreed to monitor implementation of joint CCG/BSUH/BHCC action plan (autumn 19?) **Contacts:** Jayne Black (BSUH) Grace Hanley (HASC) SCFT David Liley (Healthwatch)
Sussex-wide Review of Mental Health Services for Children & Young People	CCG report on review of YP MH services	CCGs	**Contacts:** Sarah Lotts (CCGs)
14 OCTOBER 2020 HOSC			
NHS 999	Report on 999 performance	Sussex Integrated Urgency Care Transformation Programme (NHS commissioning)	**Contacts:** Colin Simmons (CCGs) Helen Wilshaw (SECAmb)
OTHER POTENTIAL ITEMS			
Patient Transport Services (PTS)	Report on plans to tender PTS (end of contract)	Sussex Integrated Urgency Care Transformation Programme (NHS	**Contacts:** Colin Simmons (CCGs)

		commissioning)	HOSCs will be watching this re-procurement closely given major problems with tender of previous PTS contract