

Brighton & Hove Shared Delivery Plan Objective Performance Table

Place	Deliverable	Measure of Success	Timeframe	RAG Status	Narrative
B&H Place	MCN Integrated Community Teams frontrunner: Through our multi-disciplinary team pilot we will trial and develop a new integrated model of care and support for people with multiple compound needs and their carers. This will be supported by a clear set of programme objectives, a compact agreement between system partners and an independent evaluation of our pilot project	We will develop a clear set of programme objectives that supports our aim of increasing life expectancy for people with multiple compound needs.	Mar-24		April 2023 our Health & Care Partnership Executive Board agreed a Multiple Compound Needs Programme Delivery Plan which had 7 specific work streams- Multidisciplinary Pilot Project, partnership & governance, data & information sharing, health inequalities, workforce development, co-production and prevention. The delivery plan is supported by an MCN Steering Group and is overseen by MCN Integration & Oversight Board
		We will establish a compact agreement, across system partners that supports a new integrated model of care and support.	Mar-24		In January 2024 we established the Multiple Compound Needs Oversight & Integration Board which is made up of Executive leadership from each of the key partners. The Board agreed the principles for the a Compact Agreement with the aim this will be finalised and signed off in the spring of 2024
		We will get an independent evaluation of our pilot project to inform future service design and commissioning	Dec-24		We have selected an external partner Imogen Blood Associates in partnership with the University of York. They will start working with our pilot project this month and provide a final evaluation report in December 24
B&H Place	Health inequalities: We will build on the work with Public Health to reduce the spread of blood borne viruses. We will deliver the aims of our current commissioned health inequalities services working with the local population, VCSE and our providers to respond to known areas of health inequalities.	We will improve experience, access, and outcomes for the most disadvantaged communities in Brighton and Hove.	Mar-24		Through NHS Health Inequalities funding linked to the national CORE20Plus5 programme. 7 VCSE schemes were funded over 23/24. Each scheme has been successfully delivered and the learning and evaluation of each programme is being completed and will inform our local ICT development
		We will build on HIV ED opt- out testing and commence the opt-out blood borne testing.	Mar-24		ED Opt out testing at Royal Sussex County Hospital now business as usual
B&H Place	Children and young people (CYP): We will implement Year One emotional wellbeing action plan priorities for the Foundations for Our Future Placebased Plan. This will include a new emotional wellbeing pathway for CYP	We will improve the support and interventions for children and young people who are neurodiverse and for children and young people with mental health needs and their carers.	Mar-24		Foundations for our Future Strategy being rolled out across Sussex with a local B&H Action Plan which was updated in Jan 24 and is supporting- integrated working across all ages wellbeing service, schools wellbeing service & CAMHS, development of single point of access and MAMHET triage service. improvement in communication for parents & carers. CYP input into our local suicide prevention plan.
B&H Place	Mental health: We will implement the recommendations of the 2022 Mental Health and Wellbeing JSNA ensuring that progress is made across all seven delivery areas - extend and expand the range of emotional wellbeing services to Primary Care Networks, physical health checks for people with severe mental illness, develop suicide and self-harm prevention action plan.	Increase access to community mental health services.	Mar-24		Community mental Health Transformation Programme being rolled out across Sussex, good progress has been made in establishing integrated mental health support across most PCNs in the city.
		Reduce demand on acute and crisis care.	Mar-24		There are 5 high impact objectives agreed as part of the Mental Health Urgent & Emergency Care Programme. These are being implemented, but within acute mental health system under considerable pressure
		Increase the number of people on severe mental illness registers	Mar-24		Rolling 12 month target was to undertake 1,969 health checks of people on the SMI register. Current performance is 1,355. A task and finish group is working on an action plan to improve performance
		Develop a suicide and self harm prevention action plan	Mar-24		Action plan has been developed, been presented across the system and is being rolled out

B	Complete / Fully Delivered
G	On Track
A	Amber - Off track. Full resolution plan identified.
R	Red - Off track. Full resolution plan not identified.
W	White - Not started

B&H Place	<p>Cancer: We will build on the work with Public Health, the local population, VCSE and our providers to help to detect cancer at an early stage through promoting uptake of screening programmes, including expanding the targeted lung health checks programme, Faecal Immunochemical Test (FIT) testing and continuing the fibro scanning outreach service (to check for liver inflammation). The programme will ensure it responds to known areas of health inequalities.</p>	<p>Increased screening rates including in areas of deprivation and communities, including BAME communities, people experiencing homelessness, Trans people and people with learning disabilities.</p>	Mar-24	<p>Cancer screening</p> <ul style="list-style-type: none"> •Act Together on Cancer are continuing promotion especially for Cervical Screening during the January awareness week. They are also developing the co-produced videos after undertaking a gap analysis for B&H. •Whole life screening timelines are now available in multiple languages and are inclusive of all genders eg using 'people with a cervix' instead of 'women' •B&H Public Health are investigating some screening uptake anomalies within the nationally published data regarding deprivation in B&H. •Ovarian and renal cancer early diagnosis project commenced in January to increase the numbers found at stage 1 and 2 and we are preparing for the March awareness month. •The Brighton and Hove GP Federation is opening its cervical screening Hub to deliver out of hours access. •High Risk Liver Surveillance has found its first cancers amongst the target group. • increased Bowel cancer testing is impacting on the number of colonoscopies and hospital referrals but a lack of national data due to IT problems is delaying a full impact and activity assessment. <p>Targeted Lung Health Checks</p> <ul style="list-style-type: none"> •Completing Crawley and B&H programmes in Feb 24 •Held drop in sessions for homeless populations in B&H in Dec 23 •76% of lung cancers now being identified at early stage <p>Teledermatology for Urgent Suspected Skin Cancer</p> <ul style="list-style-type: none"> •UHSx pilot continuing until April 2024 •72% of patients managed virtually, avoiding hospital visit •B&H suspected skin cancer pathway development underway for 24/25
B&H Place	<p>Multiple long-term conditions: We will develop our cardiovascular disease reduction priorities in Brighton and Hove including hypertension case finding and treatment, and the restoration of the NHS health checks programme with health inequalities lens.</p>	<p>The cardiovascular disease reduction action plan will be developed and monitored at Brighton and Hove Community Oversight Group.</p>	Mar-24	<p>B&H Cardiovascular disease reduction plan still in development</p>
B&H Place	<p>Hospital discharge: We will develop our integrated model, implement the 2023/24 hospital discharge transformation plan, and deliver the improvements aligned with the discharge frontrunner programme. Our Place-based discharge transformation work will happen to ensure efficiency within current processes.</p>	<p>This will enable us to ensure people who no longer need acute inpatient care can go home or to a community setting to continue recovery with appropriate support for any unpaid family/friend carers who help that patient.</p>	Mar-24	<p>Brighton & Hove Discharge Transformation Programme</p> <p>This is in line with the recommendations from the system's externally commissioned report by Professor John Bolton that we shift from bedded to non-bedded care, learning from 23/24, and the need to be assured on Value For Money and efficiencies to inform 24/25 - this is an ask for the system leaders.</p> <p>Below are some key highlights shown below including impact/outcomes:</p> <ol style="list-style-type: none"> 1. 24/25 Discharge Monies – working collaboratively to increase discharge to assess reablement (D2AR) Home First capacity, specialist beds and reablement ensuring alignment with John Bolton recommendations (a) Reduction of pathway 2 beds by 30% – MRDs haven't necessarily increased due to work in Home First providing assurance of pathways (b) Flexible solutions (integration) for delirium and dementia (Partridge House beds) (c) Wider bed planning for complex discharge pathway 3 D2AR model – for those patients above BHCC scope but below AACC (CHC) scope (d) Independence at Home (I@H) transformation – working collaboratively to sit alongside Home First, take Trusted referrals, and provide therapy oversight (e) Increase in reablement beds/therapy access – incl. location (base) for I@H with therapeutic access (Cravenvale beds) 2. Transfer of care hub (ToCH) – co-location started (RSCH Trust HQ board room) and ToCH Lead (RSCH/PRH) appointed and to start 18 March 2024 3. Long length of stay (LLOS) 21+ day senior reviews (RSCH/PRH) - reduction in 30% of patients delayed/delay days since starting new process 4. Increased BHCC social work capacity in Home First – remove blockers for assessment delays 5. New BHCC domiciliary care contract, and improvements to CMT sourcing – seeing good outcomes 6. Same Day Discharge Team (APT) – approx. 1000 patients screened and 500 discharges since team started in June 2023 (approx. 50% of patients who are screened are discharged) 7. Carer Link Workers (based in RSCH ToCH) – 4x increase in referrals from increased variety of staffing groups to the B&H Carer's Centre