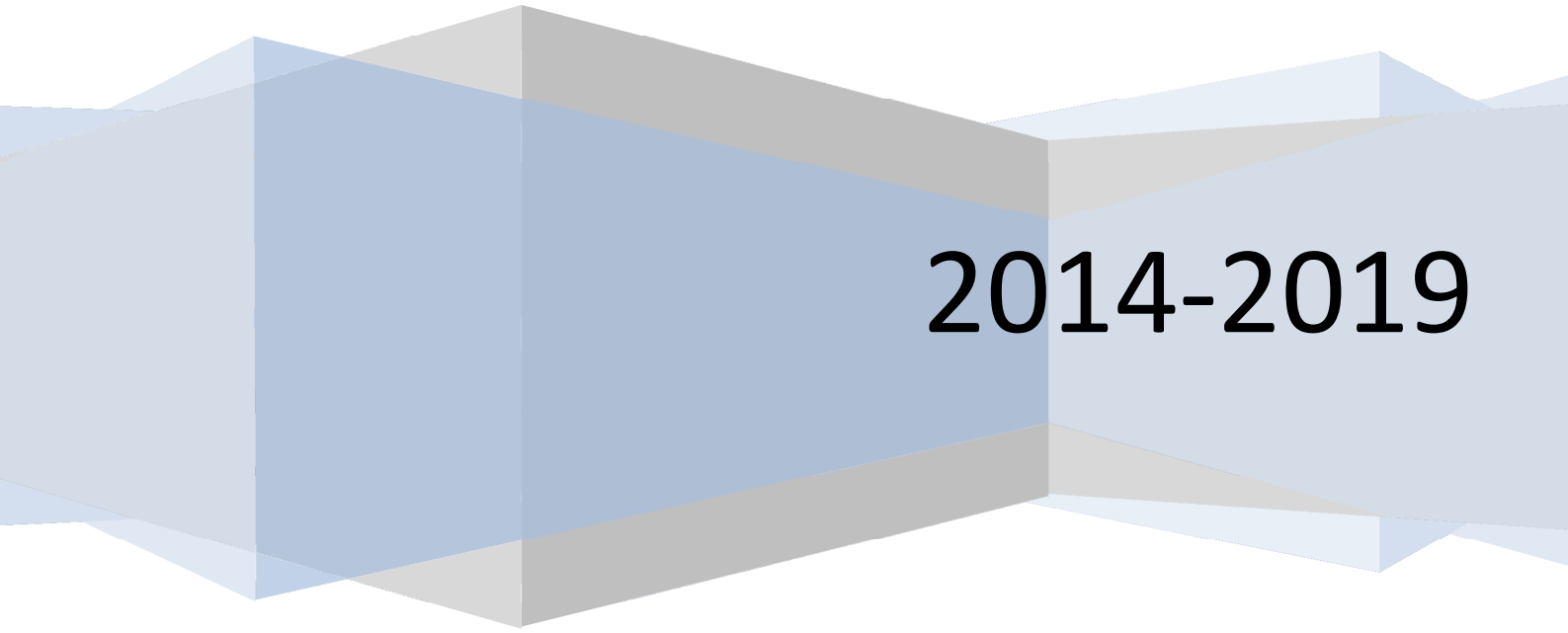
Brighton and Hove Clinical Commissioning Group

5 Year Plan



2014-2019

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Brighton and Hove CCG 5 year Strategic Commissioning Plan

Chapter 1 – Introduction and Strategic Context

Introduction and Context

The 2014-2019 Strategic Commissioning Plan builds on and refreshes the 2012-2017 Strategic Commissioning Plan. It demonstrates how Brighton and Hove Clinical Commissioning Group (CCG) will harness its clinical and managerial skills, expertise and energy to improve the quality and outcomes of healthcare for our population in the context of the financial challenges facing the NHS.

Our commissioning will continue to be based on local population needs and priorities as identified through the Joint Strategic Needs Assessment and aligned to the local Health and Wellbeing Strategy. It will also be shaped through the engagement of our member clinicians, patients, public and other stakeholders.

Clinically lead commissioning provides Brighton and Hove with a unique opportunity to rebalance the healthcare system by focusing on developing more preventative, proactive care. We will do this by investing in primary and community services rather than continuing to rely on a reactive, bed based model that is ultimately not sustainable.

We see excellent primary care as the bedrock of our healthcare system. Our vision is for a high quality and sustainable model of primary care in the City, one in which practitioners feel supported and valued in their role and work in partnership with their patients to promote health and wellbeing, pro-actively identify and manage long term conditions and other illnesses, and where all aspects of care and support are co-ordinated around the patient. By delivering an excellent primary care service we will address many of the inequalities of health that exist in our city, narrow the gap in life expectancy, improve health outcomes and deliver a better experience of care for all.

Delivery of care outside of hospital is essential to the delivery of a proactive model of care but is also necessary in order to free up capacity on the Royal Sussex County site to take on increasingly specialist work and repatriate activity from other parts of the County and South East. We see the development of the new hospital buildings as essential to improving provision of district general hospital services to our local population but also to allow the repatriation of work in line with the Trusts increasingly specialist role.

As a commissioning organisation we are not afraid to use competitive procurement processes and contractual levers where we believe this is the best way of delivering better quality care, improving outcomes and adding social value in the City. We will move away from contractual regimes that reward activity to models of care that are funded on the basis of outcomes.

Our plan is to build on firm foundations: a collective vision for our health economy, strong working relationships with partners; national directives and guidance; a good understanding of local needs and priorities and an absolute commitment to engage and listen to the people we serve.

The national and local NHS environment will continue to change but we are confident that we

are well placed to manage that change, meet the challenges it will bring and successfully deliver a high quality health care system and ultimately deliver better health and healthcare for the people of Brighton and Hove.

Strategic Context

NHS Mandate

The NHS mandate plays a vital role in setting out the strategic direction for the NHS. It is the main basis of Ministerial instruction to the NHS, which must be operationally independent and clinically-led. Other than in exceptional circumstances, including a general election, it cannot be changed in the course of the year. The Mandate is therefore intended to provide the NHS with much greater stability to plan ahead.

The objectives of the mandate focus on those areas identified as being of greatest importance to people. They include transforming how well the NHS performs by:

- preventing ill-health, and providing better early diagnosis and treatment of conditions such as cancer and heart disease, so that more of us can enjoy the prospect of a long and healthy old age;
- managing ongoing physical and mental health conditions such as dementia, diabetes and depression – so that patients and carers experience a better quality of life; and so that care feels much more joined up, right across GP surgeries, district nurses and midwives, care homes and hospitals;
- improving recovery from episodes of ill health such as stroke or following injury;
- making sure patients experience better care, not just better treatment, but treatment with compassion, dignity and respect;
- providing safe care – so that treatment is in a clean and safe environment and comes with a lower risk of infections, blood clots or bed sores

These areas correspond to the five domains of the NHS Outcomes Framework. The framework will be kept up to date to reflect changing public and professional priorities, and balanced to reduce distortion or perverse incentives from focusing inappropriately on some areas at the expense of others. In order to allow space for local innovation at the front line, both the Government and the NHS England will seek to ensure that local NHS organisations are held to account through outcome rather than process objectives.

As part of this, the Government has identified the following priority areas where it is expecting particular progress to be made:

i. improving standards of care and not just treatment, especially for older people and at the end of people's lives;
ii. the diagnosis, treatment and care of people with dementia;
iii. supporting people with multiple long-term physical and mental health conditions, particularly by embracing opportunities created by technology, and delivering a service that values mental and physical health equally;
iv. preventing premature deaths from the biggest killers;
v. furthering economic growth, including supporting people with health conditions to remain in or find work.

Call to Action

The publication, 'The NHS belongs to the people: a call to action' sets out the challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of care. The document says clearly

that the NHS must change to meet these demands and make the most of new medicines and technology.

Everyone Counts: Planning for patients 2014/15 to 2018

This planning guidance sets out how the NHS should continuously improve to ensure high quality care for all, now and for future generations. The guidance contains 4 aims:

- **High quality care**. We will be driven by quality in all we do. No longer can we accept minimum standards as good enough – our patients rightly expect the best possible service.
- High quality care **for all**. We need to ensure that access to all services is on an equal footing whether the patient's need is for mental or physical help and support. We must put the greatest effort in providing care for the most vulnerable and excluded in society.
- High quality care for all, **now**. But high quality is not just an aspiration. The NHS provides high quality care, often to the highest standards of anywhere in the world, but we need to spread excellence more widely. We have to learn from the best and get better at sharing good practice rapidly across the NHS.
- High quality care for all, now **and for future generations**. We are investing not just for today but for the future. We have a responsibility to ensure that the NHS is on as strong a footing as possible, capable of remaining focused on quality through the significant economic challenges ahead. There is great urgency to plan strategically to start making the changes that are required to deliver models of care that will be sustainable in the longer term.

The planning guidance is bold in asking commissioners to work with providers and partners in local government to develop strong, robust and ambitious five year plans to secure the continuity of sustainable high quality care for all, now and for future generations.

Chapter 2: Local Context

CCG Vision, Values and Principles

The Governing Body and Clinical Leaders in the City have worked collaboratively with patients, the public and other stakeholders to collectively agree a system vision for the local health economy. The vision states that in the next five years we aim to:

1. Align our commissioning to the health needs of our population and ensure we are addressing health inequalities across the City;
2. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care
3. Increase capacity and capability in primary and community services so that we focus on preventative and proactive care – particularly for the most frail and disadvantaged communities;
4. Plan services that deliver greater integration between health, social care and housing and promote the use of pooled budgets;
5. Design high quality urgent care services that are responsive to patient needs and delivered in the most appropriate setting;
6. Integrate physical and mental health services to improve outcomes and the health and wellbeing of all our population;
7. Deliver a sustainable health system by ensuring our clinical care models, commissioning and procurement processes and internal business practices reflect the broader sustainability agenda and deliver on our duties under the Social Value Act.
8. Exploit opportunities provided by technology to deliver truly integrated digital care records, derived from the GP Record as the primary source which will be made 'Fit for caring, fit for sharing' through a programme of information management and data quality initiative

We will deliver the system vision and characteristics of a high quality system (as defined by Everyone Counts: Planning for patients 2014/15 to 2018) through a series of improvement interventions underpinned by good governance arrangements where assurance and quality is at the heart of every service development and monitored in a systematic and inclusive manner. Chapter 3 of this document describes in more detail how we will deliver our vision.

The following values and principles underpin the development of these plans and the working practices of the CCG:

Key Values

- We are committed to making decisions openly in a way that is easily understood.
- We place patients, their families and the public at the centre of everything we do.
- We value innovation and will create an environment that supports good ideas.
- We take time to celebrate achievements.
- We listen to and respect patients, the public, staff and clinicians.
- We value the highest standards of excellence and professionalism in the provision of health care that is safe, effective and focused on patient experience.
- We value and uphold the NHS constitution in all that we do.

Principles

- We will clinically lead our local healthcare system to improve the quality, effectiveness and outcomes of NHS health care.
- We will ensure the best possible stewardship of NHS funds.
- We will promote equality through the services we commission and pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.
- We will work to reduce health inequalities and seek to identify and eliminate discrimination.
- We will involve patients, their families and the public in all decisions about their care and treatment and the design of NHS services in our City.
- We will support the education, training and development that the staff of the CCG and member practices to improve the current and future healthcare of the population.
- We will bring our member practices together to work effectively for the benefit of the whole population.
- We will work across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population, to create a happier healthier City.
- We will minimise waste and bureaucracy.

Demographics of the City

Brighton and Hove CCG covers a geographical area of approximately thirty four square miles and shares the same boundaries as Brighton and Hove City Council.

Brighton and Hove has an unusual population distribution with relatively large numbers of people aged 20 to 44 years, relatively fewer children and older people, and relatively more people (particularly women) aged 85 years or over who are likely to need more services. The diagram on the following page illustrates the significant difference between the local population and that of England as a whole:

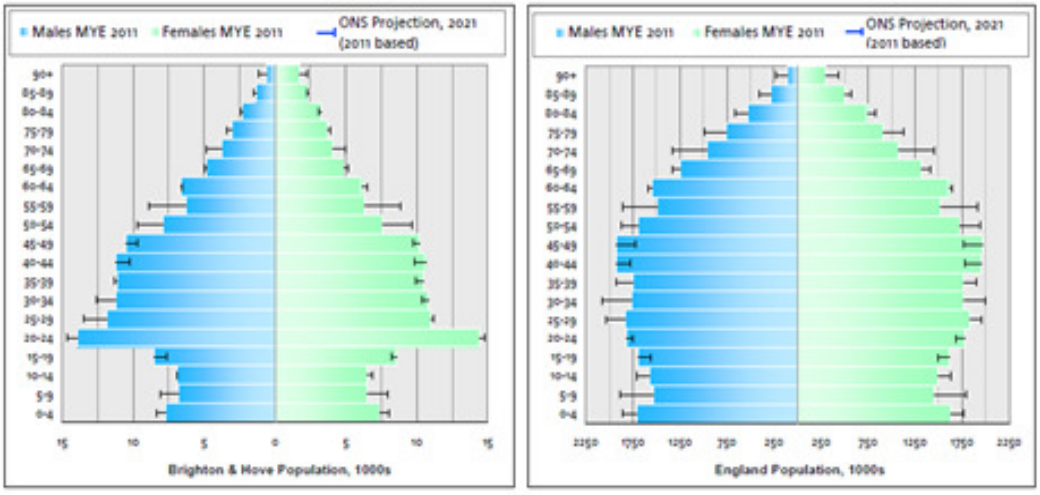

Figure 1: Population Pyramid – Mid Year Estimates 2011 and Projected Population for 20121

The 2011 census highlights the considerable change in the population of Brighton and Hove over the last ten years particularly in respect to our BME population, older people and working age adults. The diagram on the next page shows the increases and decreased reflected in the census:

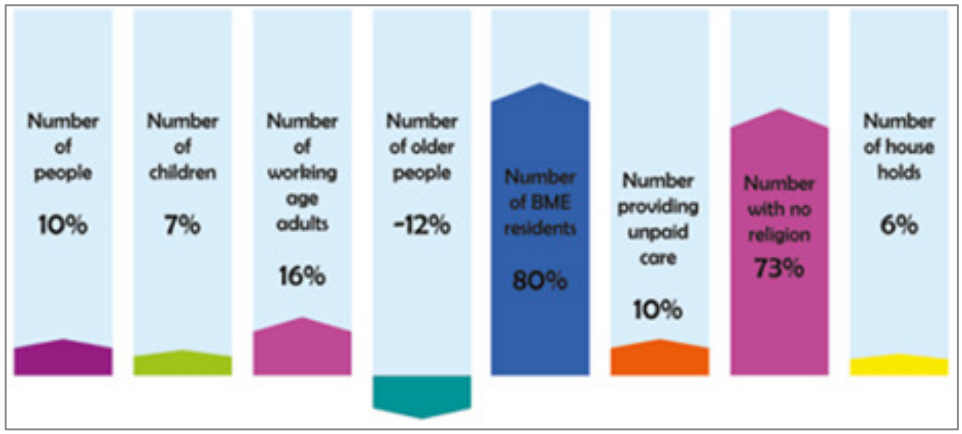

Figure 2: Change between 2001 and 2011 Census in Brighton and Hove

Predicted future need

Changes in the population age structure affect the need for health and social care services. Population projections therefore have an essential role in assessing the future need for services. Current trends in births, deaths and migration are projected forwards and used to produce population projections.

Over the next ten years we forecast on-going changes to our local population. The resident population is predicted to rise to 289,900 by 2021 (6% increase from 2011) –16,900 more people. The greatest projected rise will be seen in the 25-34 & 50-59 year age groups. There are also projected to be higher numbers of children under 15 years. The number of people aged 75 years or over is expected to rise by 10% from 18,272 in 2011 to 20,085 in 2021. We also forecast a rise in the number students associated with the expansion of the existing Universities in the City.

Key population groups within the city

Brighton and Hove City has a unique and diverse population. The following are some of the key population groups within the city and considered in our plans:

- *BME groups* – The 2011 Census shows that 19.5% of the city's population are from a BME group.
- *LGB* - Estimates suggest that there may be 40,000 people from Lesbian, Gay, Bisexual (LGB) communities living in Brighton & Hove, around 15% of the city's population.
- *Carers* - 9% of the population (approximately 24,000 people)
- *Migrants* - 2010 figures show that 15% of the city's population was born abroad.
- *Students* - there has been an increase in the numbers of students in the city to more than 35,200 in 2011/12. This is approximately 13% of the total population.
- *Military veterans* – an estimated 17,400 military veterans live in the city.
- *Gypsies and travellers* – an estimated 198 gypsies and travellers
- *Homeless* – there are approx. 3000 homeless people in Brighton and Hove

In terms of the highest levels of need for excluded communities, local research (Public Health needs assessments and others) has shown that the most acute and worrying needs exist for Traveller, Transgender and Homeless people.
Our plans respond to the changing and diverse nature of the local population and our work programme is prioritised on the basis of need.

Chapter 3: Delivering the vision

This chapter takes each element of the system vision and describes how and what the CCG will deliver over the next five years. Detailed project plans can be found in our 2 year operating plan.

Needs Based Commissioning

Align our commissioning to the health needs of our population and ensure we are addressing health inequalities across the City

We identify need by working with public health staff to develop the overview of local health and wellbeing needs, and inequalities, known as the Joint Strategic Needs Assessment (JSNA). This comprehensive document also takes account of the patient voice, benchmarking and activity data, and quality indicators.

The JSNA enables us to understand the different needs of people in different areas based on factors such as the age structure of the population, socio-economic status, ethnicity, and access to health services which are all associated with particular health risks. It also allows us to identify areas where we are doing well and those which need improvement.

The health and wellbeing of our population is greatly influenced by a wide variety of social, economic and environmental factors and action to address these wider determinants is the most effective way to make improvements in health outcomes. This section sets out some of the issues that are considered key to Brighton & Hove.

- Child poverty: National data for 2010 suggests that approximately one in five children in Brighton & Hove live in poverty which is similar to the national average and to levels in some other nearby cities. However, it is significantly higher than the South East Coast average which has the lowest regional rate in the country.

- Employment and unemployment: In 2012 the employment rate in the city was 71% of people of working age, which is similar to the national rate but lower than the South East Coast. In total there are estimated to be 11,800 unemployed people in the city.

- Education: In 2012 56.4% of pupils achieved 5 A*-C grades including English and Maths in Brighton & Hove (compared with 59.4% for England). However, provisional figures for 2013 suggest that local performance improved to 62% (final confirmed local data and comparative data for England will be published in 2014).

- Housing and homelessness: Housing pressures have seen homelessness increase by nearly 40% over the last three years with the most common reasons being eviction by parents, family or friends (38%) and loss of private rented accommodation (30%). A third of the city's housing stock (up to 40,000 homes) is considered to be non-decent with the vast majority (92%) being in the private sector; 42.5% of all vulnerable households in the private sector are living in non-decent accommodation

- Fuel poverty: In 2011, 12.2% (14,500) of households in the city were estimated to be fuel poor (defined as a household needing to spend more than 10% of its income to maintain an adequate level of warmth). People living in cold homes during the winter months are at increased risk of ill health and death. In Brighton & Hove from 2008-11 there was an average of 135 'excess winter deaths' per year (equivalent to a similar rate to the South East but slightly higher than England).

The key health and wellbeing issues currently facing Brighton & Hove including health related behaviours and specific conditions that contribute to both early mortality and reduced quality of life are summarised below.

- Alcohol: 18% of adults in the city are believed to engage in increasing or higher risk drinking. Rates of alcohol-related A&E attendance and hospital admissions have increased in recent years, and in the Big Alcohol Debate, 36% of respondents were worried about the effect alcohol has on people in the city. In addition, the city faces challenges from substance misuse and there were 1,582 clients in drug treatment during 2012. A third of this client group had been in treatment for over four years.

- Healthy weight: Overweight and obesity are major risk factors for diseases such as Type 2 diabetes, cancer and coronary heart disease. In terms of children in the city, in 2011/12, 15% of Year 6 pupils in the city were obese which is lower than England at 19% while almost 8% of reception children were obese which is also lower than England at 9.5%. For adults, data suggest that in Brighton & Hove, 20% of adults are obese compared to 24% nationally, and an estimated 3% are morbidly obese which is similar to national levels.

  In terms of healthy eating, the 2012 Health Profile for Brighton & Hove indicates that 30% of adults are eating a healthy diet, which is similar to the England average of 29% and between 2003 and 2012 there was a significant increase in the proportion of residents eating 5 portions of fruit and vegetables a day – from 43% to 52%.

- Domestic and sexual violence: In 2012/13, almost three and a half thousand domestic violence incidents were reported to the police in Brighton & Hove, a slight increase from the previous year. There were also 373 police recorded sexual offences, an increase of 12% compared with the previous year although these figures are likely to be underestimates since many people do not report such violence to the police.

- Emotional health and wellbeing: Nationally one in ten children aged 5-16 years are thought to have a mental health problem which would equate to nearly 4,000 children in Brighton & Hove. In adults, 13% have a common mental health disorder while 1% have a more severe disorder. Both of these figures are higher than across the country as a whole. Despite this, local surveys have suggested that a large proportion of people are emotionally well with over 70% of adults indicating that they are happy with their lives and feel that the things they do are worthwhile.

- Smoking: In Brighton & Hove, prevalence of smoking is 23% which is higher than the national figure of 20%. On average there are 381 smoking related deaths per year in Brighton & Hove, which again is higher than the national average. However, the city did have a significantly higher rate of successful quitters in NHS Stop Smoking Services than the England average.

- Disability: People with physical and sensory disabilities are more likely to suffer discrimination, poor access to some health services and worse employment prospects, each of which can impact negatively on health. It is estimated that in Brighton & Hove in 2012 there were almost 17,000 people aged 18-64 with a moderate or severe physical disability, approximately 3,500 people with a moderate or severe visual impairment and approximately 23,000 people with a hearing impairment.

The JSNA also identified five key health needs in the city:

- Cancer and screening access: Mortality from all cancers in under 75 year olds is significantly higher in Brighton and Hove than England and the South East. There are three NHS cancer screening programmes in England: breast, cervical and bowel and in Brighton & Hove, screening uptake rates are generally lower than both regional and national figures. Cancer and cancer screening is identified as one of the five priorities in the Joint Health and Wellbeing Strategy (JHWS).

- Diabetes: The prevalence of diabetes is increasing nationally due to increased obesity, an aging population and increasing numbers of South Asian people, who are at

greater risk of developing diabetes. In Brighton & Hove numbers have also increased with 3.3% of people registered with GPs having diabetes in 2012 compared with 2.9% in 2008. The CCG plans to commission an integrated diabetes service in 2015 to improve the quality services and drive up health outcomes.

- Coronary Heart Disease: Despite reductions over recent decades, coronary heart disease remains the most common cause of death nationally. It was the main cause of death for 218 people in Brighton & Hove in 2011 which was approximately 10% of all deaths. In 2011/12 2.3% of all patients registered local GPs had coronary heart disease. The Better Care Plan includes in its definition of frailty a cohort of patients with CHD and outlines how we will improve services for these patients. The CCG is currently undertaking a Preventing Premature Mortality Audit the results of which will be used to inform changes in Primary Care to improve care for patients with CHD.

- Dementia: It is estimated that there are currently almost three thousand people aged 65 years or over with dementia in Brighton & Hove. However this is lower than expected prevalence and therefore more needs to be done to identify this cohort. The CCG have jointly developed with Brighton and Hove City Council a Dementia Plan which describes how we will deliver local improvements in line with the National Dementia Strategy and raise dementia diagnosis rates to 67% by March 2015.

- Musculoskeletal conditions: Musculoskeletal conditions are a range of conditions including back pain, shoulder pain, hip and knee pain which can limit mobility in older people and make them vulnerable to falls. In each year it is estimated that about 40% of the adult population have lower back pain, 5% have hip pain and 60% of over 65s severe knee pain. Brighton and Hove has a high programme budget spend in this area yet has poor patient reported outcomes. To address the CCG will recommission and implement a new MSK service in 2014/15.

The JSNA also identified the following two priority areas where the CCG needs to work with commissioning partners in Public Health and Area Team to improve services:

- HIV/AIDS: In 2011 Brighton & Hove had the ninth highest HIV prevalence in England at 7.6 per 1,000 15-59 year olds compared with 1.7 in England as a whole and the highest prevalence anywhere outside of London. Brighton and Hove also has the highest rates of common sexually transmitted infections outside London. The CCG will continue to work with our public health colleagues to improve the sexual health of the residents of Brighton and Hove.

- Influenza immunisation: Influenza is a highly contagious viral infection that can cause serious illness and death, especially in vulnerable groups including very young and elderly people. Immunisation is available for people in these groups including everyone over the age of 65. In 2012/13, uptake in Brighton & Hove among those eligible was just under 70%, which is a slight decrease from the previous year, lower than England as a whole and below the national target of 75%. This year we used an incentive scheme for GPs to increase the numbers of flu vaccines they gave out and worked closely with the hospital to support them in vaccinating at risk groups. However we know our numbers could always be improved so together with public health colleagues we commissioned a large piece of social marketing research (funded by public health) to find out what the barriers are to people having their flu vaccine, for example why don't older people come in. We will be using these findings to inform this year's plan and have set up a working group to look at how we can get the message about the flu vaccine out to over 65s.

Health inequalities

We need to ensure that the most vulnerable in our society get better care and better services, often through integration, in order to bring an acceleration in improvement in their health outcomes.

Life expectancy in the Brighton and Hove City is higher than it has ever been. Women in the City can expect to live on average to 82.6 years and men 78.5 years. This is lower than the national average by 2.5 months and almost 3 months respectively for women and men. Additionally, within the City we see a significant difference in life expectancy between wards. Women living in the most deprived parts of the city have a life expectancy of 80 years compared to 84.4 years for women living in the least deprived area. For men there is a gap of 10 years with men in the most deprived and least deprived areas expecting to live to 71.7 years and 81.7 years respectively.

In order to address the gap in life expectancy and improve mortality and morbidity in the City overall, the CCG plans to commission a range of high impact, evidence based interventions to improve health outcomes supported by improved Business Intelligence tools and facilitated GP audits (see list in following section).

Improving Health

Improving health, must have just as much focus as treating illness. At a local level we are working closely with our public health colleagues and the Health and Wellbeing Board to ensure our Joint Health and Wellbeing strategy will deliver the required levels of improvement. We are making the necessary changes to the shape and function of the Health and Wellbeing Board to reflect the increased level of integration between partners in the local health economy.

The type of evidence based interventions being considered are summarised below. These will be prioritised for investment following the outcome of the local Preventing Premature Mortality Audit.

- **Cardiovascular disease: Secondary prevention**- Four treatments (beta blocker, aspirin, ACE inhibitor, statin) for all patients with a previous CVD event (currently untreated and partially treated)
- **Additional treatment for hypertensives with no previous CVD event**- Additional hypertensive therapy
- Statin treatment for hypertensives with high CVD risk.
- **Treatment for heart attack**- Primary angioplasty (PCI) for heart attack.
- **Anticoagulant therapy (Warfarin) for all patients over 65 with atrial fibrillation**
- **Diabetes -**Reducing blood sugars (HbA1c) over 7.5 by one unit
- **Chronic obstructive pulmonary disease (COPD**) - Statins to address CVD risk among COPD patients
- **Reducing smoking in pregnancy** - Eliminating smoking in pregnancy (infant deaths averted)
- **Harmful alcohol consumption** - Brief intervention for 10% of harmful drinkers
- **Lung cancer** - Increasing rates of early presentation

- **Smoking cessation clinics (setting a quit date) -** Increasing rates of early presentation

Delivering successful interventions of the type described above will depend on understanding variances in primary care outcomes and building capacity to address this within primary care. This will be supported through deploying integrated GP data extraction and business intelligence tools. Drawing on examples of successful models elsewhere and building on our primary care development strategy we will work with member practices on potential models for delivery which will also address:

- Greater consistency of achievement for QOF clinical indicators associated with premature mortality within and between General Practices;
- Higher achievement of QOF clinical outcomes moving closer to ONS peer comparators and England average;
- Reducing the prevalence gap between those with risk for conditions not yet identified in the community and those on Practice registers;
- Promoting peer challenge and learning based on benchmarking of achievement and identification of good and effective practice in General Practice;
- Identification of the clinical indicators within General Practice most strongly associated with premature mortality;
- Agreement of acceptable thresholds for exception reporting for clinical indicators most strongly associated with premature mortality;
- Enhancing the reach of primary care to identify those with risk – improve access and reach;
- Increasing capacity within General Practice to assess risk, register, treat and review new patients for major killers: COPD, CHD, stroke, diabetes;
- Incentivising higher achievement for clinical indicators associated with reducing premature mortality;
- Incentivising reducing exceptions for agreed indicators;
- Enhancing CQUINS in acute settings: e.g. smoking cessation;
- completion of stage 4 cardiac rehabilitation

The outcomes of the PPMA will be shared with member practices in Summer 2014. The CCG will work with members to prioritise the resulting programme of work.

Participation and Empowerment

Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

We are determined to put patients at the heart of what we do as a CCG and see shared ownership of the commissioning agenda and shared responsibilities for health as a key priority.

We recognise that patients want to be fully engaged in making choices about their care and to deliver this we will ensure that every person with a long-term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health. As stated in the NHS England Business Plan 'Putting Patients First', 'by 2015 the CCG will commission to support patients' participation and decisions over their own care.

We plan to review our engagement strategy and refresh it in light of best practice and the duties set out in Transforming Participation in Health and Care. We have a good track record of engaging with patients in service design but recognise we could do better at feeding back on how the patient voice is translated in to meaningful service improvement. In response to this we are currently undertaking a three month consultation in the city covering the following areas:

- Individual Participation – people in control of their own care
- Public Participation – communities with influence and control
- Insight and feedback – understanding peoples experience.

The consultation will shape the new CCG participation strategy due for publication in September 2014.

In the meantime we will continue to engage though our existing mechanisms:

- Practice level Patient Participation Groups;
- A network of Patient Participation Groups members from across the city;
- Public and patient representatives on our three Local Member Groups;
- CCG funding of mechanisms to reach seldom heard/chronically excluded groups;
- A city-wide participation forum that brings together members of the third sector, neighbourhood and community groups, patient participation groups and Healthwatch.
- Bi monthly public events to seek feedback on service change

In five years' time we hope that patients and the public recognise the changes in the health service that have been driven by their feedback and views. We will develop a consistent comparable measurement to demonstrate this improvement

Primary Care Development

Increase capacity and capability in primary and community services so that we focus on preventative and proactive care – particularly for the most frail and disadvantaged communities

We see high quality primary care as the foundation on which to build the very best healthcare for the population of Brighton and Hove. Our vision is for a consistently high quality and sustainable model of primary care, one in which practitioners feel supported and valued in their role. It does not necessarily mean care delivered by a GP, but we do see GPs at the centre of patients' care, co-ordinating and overseeing the input from other clinicians and healthcare providers. They should work in partnership with their patients to promote health and wellbeing, and pro-actively identify and manage long term conditions and other illnesses. All aspects of care and support should be co-ordinated around the patient. By delivering an excellent primary care service we will address many of the inequalities of health that exist in our city, narrow the gap in life expectancy, improve health outcomes, and deliver a better experience for everyone.

In order to achieve this we will:

- Help direct patients and the public to the right level of support and advice to keep them well;
- Forge greater working relationships between primary care and the wider health and social care system, including the third sector
- Invest the necessary resources to expand primary care and rebalance the healthcare system from one that is bed-based and reactive to one that is community-based and proactive;
- Support collaboration between Practices in order to provide a more efficient, resilient and sustainable model for primary care;
- Develop and support the workforce in primary care through education and training;
- Work closely with NHS England to improve the quality of premises from where healthcare is delivered;
- Improve and streamline access for patients to primary care, particularly out of hours and when they have an urgent need;
- Facilitate greater exploration and coordination of IMT and innovation as ways to improve health and care;
- Engage more proactively with universities, exploring opportunities for research;
- Routinely review and report on the quality of primary care services, and facilitate its continued improvement through peer to peer quality visits
- Support all practices to develop thriving Patient Participation Groups;
- Address variation in quality by commissioning city-wide services, ensuring all patients regardless of where they live have access to the same quality and level of care;
- Promote self-care and support self-management across all care pathways and integrate support for both physical and mental health;

Access

Inequalities in access to general practice have been a concern for many years. We will explore mechanisms to allow patients to access care through novel means, potentially including via pharmacists and the voluntary sector. This may also include, at certain times, being able to

see members of the general practice team at premises other than their registered practice.

Changes to the GMS contract and the introduction of the enhanced service to reduce non elective hospital admissions will increase access for those at risk of hospital admission in 2014/15.

In addition to this we will strive to increase access to primary care services for routine care and aspire to provide services 24 hours a day 7 days a week by 2018/19. This will be through a variety of means including face to face, telephone and via walk-in clinics.

Collaboration

In line with the vision for future primary care outlined by various groups including NHS England, RCGP, GPC and The King's Fund, we will continue to support our member practices to have discussions about models and functions of collaborative working to develop the sustainable future of General Practice. We will continue to revisit this principle, as we believe various changes are likely to necessitate a variety of different solutions.

We will grow and develop productive membership engagement and encourage innovation and inclusivity amongst our member practices.

Workforce

To take forward the Primary Care Strategy we need a primary care workforce that is skilled and able to deliver best practice to all age groups. The delivery of best practice care can markedly improve clinical outcomes, for example for people with long term conditions.

We will work with our patients, members of the public, member practices and commissioning teams in the CCG to identify those services that could be provided closer to home. We will then ensure that consideration is given to ensuring that appropriate resources (including workforce) follows the patient when services move to primary care settings.

Education

We recognise that developing our primary care workforce to deliver high quality care is underpinned by access to high quality training and education and the need to develop a multi-professional workforce.

Our members will demonstrate a commitment to training and development and where relevant will look to share resources to maximise training and learning opportunities within the Primary and Community setting and across Health and Social Care.

We are committed to taking part in a Kent Surrey & Sussex (KSS) Health Education England (HEE) Pilot: a city-wide Community of Education Providers Network (CEPN). This will develop a multi-professional ethos of education in primary care.

We have increased our commissions at the University of Brighton to seven to enable more practice Nurses to undergo BSc (Hons) Specialist Practitioner awards for Practice. In recognition that there is a gap in NVQ level 3 we have increased our Foundation Degree pathway at the University to four placements.

We currently deliver a programme of PLS events informed by national evidence and local services. We will build on this programme and ensure education and training is matched to the needs of the local population and planned changes to commissioned services recognising that

GP will have an increasing role in the care for complex patients.

Premises

We recognise that whilst the CCG does not have direct responsibility for general practice premises we do have a responsibility to proactively identify issues and priorities and work with the Area Team to address these. We will work with the Area Team to agree a process of prioritisation for practices that need new premises or improvement grants. We will explore possibilities of colocation of services and sharing of local authority and 3rd sector estates where appropriate.

We will support practices to work together collaboratively to provide and deliver services and to make best use of their premises to enable a wider range of high quality out-of-hospital services in communities.

Quality

We will be open and transparent about the quality of primary care in the city and where appropriate publish quality information on our website. In 2014/15 the CCG will develop a quality assurance tool shaped and informed by our member practices and the outcome of the preventing premature mortality audit. We will use this tool to inform peer to peer discussions and drive consistent high quality care across the city.

Prescribing and medicines management

The aim is to ensure high quality and safe prescribing in primary care that takes into account existing national and local guidance. The strategy for medicines optimisation includes using medicines management resources to support GP practices in improving diagnosis, addressing unmet pharmaceutical need, reducing unsafe prescribing and improving patient use of medicines (including reducing wastage). To this end practices should continue to receive regular feedback on their prescribing, enabling benchmarking and setting of performance indicators.

The following section contains details of how we plan to strengthen community services and increase focus on preventative and proactive care – particularly for the most frail and disadvantaged communities.

Integrated Care

Plan services that deliver greater integration between health, social care and housing and promote the use of pooled budgets

Providing responsive pro-active care in the community is a key priority for Brighton and Hove CCG. We know from feedback from patients and their carers that they want services to be more holistic and more personalised. They want services to be supportive of them to achieve self-care and to be able to plan their future care (care planning); services which involve them in decisions about their care (shared decision making) and services which support them in their own homes without having to go to hospital if there are alternatives (care closer to home). These initiatives will be supported by our "Information about me and my care" portfolio including online patient GP record access, remote monitoring and telecare, potentially including smart phone apps.

Focus on Frailty

There has been a significant emphasis in our local health economy particularly over the past 12 months on how we work as a system, proactively care for frail people, keep them independent and well and provide responsive round the clock services to avoid unnecessary admission and effectively discharge people when required.

The unique demography of Brighton and Hove has lead us to believe that a focus on elderly frail alone will not deliver the sort of health improvements needed for our most vulnerable communities nor have the necessary impact on statutory service provision. For this reason we are working to a broader definition of frailty and incorporating those with complex care needs or a vulnerability to adverse health outcomes, whatever their age. We estimate that approximately 5% of our population will be defined as significantly frail i.e. will have 3 or more long-term conditions and require significant levels of care and support. It is estimated that 40% of our total health spend is aligned to this 5% of our population and in terms of improved use of health and social care services it is this cohort of people that we will be focusing on initially. The diagram below illustrates the local definition for frailty.

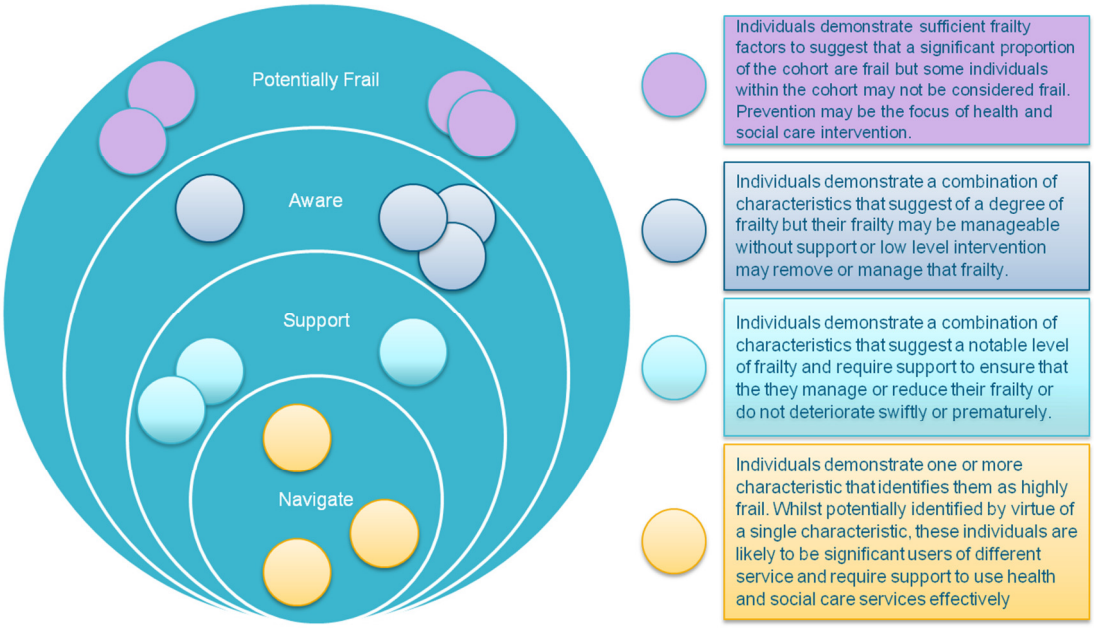

Figure 3: Brighton and Hove Frailty Model

We will improve our case finding tools in order to identify people who are frail or at risk of being frail more proactively. We currently use a risk stratification tool based on attendances and admissions into our acute hospital in order to identify those patients at most risk. This has become invaluable in working together to reduce hospital attendance and admissions, but our intention is to expand this to include not just hospital data but GP data, social care data and other relevant information to provide a more holistic picture of individual's risk.

GP's will play a significant role in local areas in supporting the coordination of people's care. In 2014/15 we will finalise our plans for use of the £5 per head of registered population (equivalent to approximately £1.5m for the City) and roll out an Enhanced Service for patients with complex health and care needs in order to support GPs deliver their role as the profession responsible for co-ordinating care around our frail population.

We will design and deliver more integrated and holistic care for all levels of frailty, starting with the cohort of people with the most complex care needs. We will build on our Integrated Primary Care Teams (a model developed 18 months ago based on the Chronic Care Management Model) be more embedded with Practice staff and extend their scope to cover all frail people registered at those practices (not just house-bound patients requiring input).

Better identification of people with dementia

We anticipate one of the key cohorts of our population that will benefit from the new MDT approach will be people with dementia and their carers'. Only one third of estimated numbers of people in the City that have dementia have a formal diagnosis. Lack of diagnosis limits access to the relevant care and support and increasing diagnosis rates is a key element of our Better Care Plan. The current system of care (which largely separates physical and mental health care) does not provide the optimal model for managing care holistically. We know from audits in acute sector activity that people with dementia are much more likely to be admitted to hospital than people without dementia and the reason for admission is related to their physical health issue (for example a Urinary Tract Infection) rather than related to their dementia. We also know that length of stay for people with dementia is longer than for people without. The new holistic model of MDT care that manages dementia and other long terms conditions will bring significant benefits in terms of the ability to provide care closer to home and reducing hospital admissions. We will invest in additional capacity within our memory assessment service to increase our identification rate to 67% in 2014/15.

Integrating care for homeless people

Given the Brighton and Hove demographics the profile of our frail population is not exclusively linked to older age and we have identified homelessness as a key element of our Better Care Plans. We have established a Homeless Board to provide sufficient strategic focus to this part of our Plans. Conceptually we will be using a similar MDT approach focused around primary care and embedding third sector support within the extended teams. The model developed will be bespoke to the community's needs and include for example greater use of out-reach models of care, investment in supported step down services from hospital, investment in additional nursing capacity in the IPCTs providing in-reach into hostels and greater support on housing related issues.

High Quality Urgent Care

Design high quality urgent care services that are responsive to patient needs and delivered in the most appropriate setting

Urgent and emergency care has been the subject of much focus at a national level. It is suggested that the current system is unaffordable and unsustainable and national figures highlight overall levels of activity and spend increasing year on year despite significant investment in alternatives. We have seen a loss of public confidence in GP out of hour's services and of the NHS 111 services.

In response to this NHS England has established a national review of emergency and urgent care services and has published four emerging principles, which the CCG has adopted:

- Provides **consistently** high **quality** and **safe** care, across all seven days of the week;
- Is **simple** and guides good choices by patients and clinicians;
- Provides the **right care** in the **right place**, by those with the **right skills,** the **first time;**
- Is **efficient** in the delivery of care and services.

At a local level, we know that despite the positive changes we have made in the system:

- Patients and the public still find it complicated and difficult to navigate;
- Patients are calling 999 and being taken to hospital when they could be supported on alternative community pathways;
- Our local acute hospital has struggled to achieve the 4 hour A&E standard and ambulance handover delays are a frequent occurrence;
- Despite year on year decreases in emergency admission, some patients are still being admitted to hospital for conditions that could be managed at home.

Our focus over the next five years will be to:

- Support patients and the public to make the right choices in accessing urgent care services;
- Streamline and integrate urgent care services so that patients get the right treatment first time however they choose to access care;
- Build capacity in primary care to manage urgent care demand;
- Work alongside the local acute hospital to achieve sustainable improvement in the A&E 4 hour standard and ambulance handover delays;
- Maximise the opportunities provided by technology to improve information sharing between professionals about patients in urgent care settings; e.g. Summary Care Record, rationalising Special Patient Notes, streamlining clinical information flows arising from urgent care events
- Deliver a further reduction in avoidable ambulance conveyances; supporting development of IBIS to integrate with SCR and other record sharing initiatives including the pan-Sussex integration engine
- Develop and implement an integrated 24/7 urgent care model.

A step-change in the productivity of elective care

We will continue to build on existing work to ensure that planned care services are high quality, accessible, timely and value for money. In particular we will ensure services:

- Provide support and education to primary care;
- Are based on evidence based clinical pathways and referral guidelines; supported by GP decision making tools and integrated referrals in our 'Better information for better decision making' portfolio
- Provide seamless and integrated care and so that the patient sees the right person the first time;
- Are convenient for the patient offering one stop facilities wherever appropriate;
- Enable patients to make informed choices about treatment options; supported by roll out of NHSE integrated customer services platform
- Have sufficient focus on supported self-care and shared care wherever appropriate;
- Take account of the psychological as well as physical wellbeing of the patient;
- Are efficient and value for money and avoid duplication
- Ensuring swift and accurate electronic communication between secondary and primary care building on Phase 1 of the Clinical Correspondence Project

The first phase of this work will focus on redesigning MSK, dermatology and diabetes services.

Maternity services in Brighton and Hove are provided by Brighton and Sussex University Hospitals Trust; there is an Obstetric Led Unit at the Royal Sussex County Hospital site or women can choose to have a home birth which accounts for about 5% of local births. Plans are being developed for a midwifery-led unity service that will provide increased capacity, a co-located birth centre and a women's health centre for both ante natal and gynaecology outpatients.

In the light of national changes in commissioning structures the Section 75 Agreement was amended in April 2013. The agreement now outlines how the City Council will deliver service improvements acting as Lead Commissioner for a range of community based services for children with disabilities and children and young people with mental health problems. The strategic aim is to ensure good integration with other services provided by the Council and across the City. The CCG will undertake a further review of this arrangement in 2014/15.

Children and Young Peoples Services are provided in the City via a number of commissioning arrangements summarised in the table below.

Lead Commissioner	Service Area
NHS England - Public Health	Health visiting, family nurse partnership and screening programmes
Public Health Team in the Council	School nursing, sexual Health, teenage Pregnancies, substance and alcohol misuse and local health promotion programmes
Brighton and Hove Clinical Commissioning Group	Acute health care including planned and urgent care, maternity and routine new-born services
Brighton and Hove City Council Section 75 Agreement with the CCG	Community health servicesincluding community pediatrics, the Integrated Disabilities Team, therapies and child and adolescent mental health services

Parity of Esteem

Integrate physical and mental health services to improve outcomes and the health and wellbeing of all our population

Parity of esteem, making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities. This means for the CCG both ensuring that sufficient commissioning focus and resources are allocated to mental health as well as ensuring that mental health is an integral part of holistic care pathways.

Improving mental health and wellbeing is a key priority for the CCG and we are striving to ensure that mental health has equal status to physical health. The City has high levels of mental health need both in terms of numbers and degree of complexity and major transformational change has taken place within mental health services over the last few years with the aim of providing preventative care and support as early as possible. This strategic approach aims to prevent problems escalating and make the best use of our available resource.

As a result of the changes we have made we now have more services are available in community settings and there is greater accessibility for example a self-referral option to the Wellbeing Service; increased provision by the community and voluntary sector, for example psycho-social and employment support; strengthened working arrangements between GP practices and providers of mental health services, for example the Wellbeing Service and Seriously Mentally Ill Enhanced Service; enhanced 24/7 crisis support services; and increased capacity in terms of supported accommodation, helping to prevent unnecessarily long stays in hospital.

The CCG also has a strategic commitment to integrate mental health into all care pathway redesign as part of a plan to move towards more holistic care. As a result of this commitment mental health is now incorporated into the new care pathways for Musculo Skeletal and dermatology services. The CCG will continue with this programme of work of integration for both individual care pathways, for example diabetes and medically unexplained symptoms as well as at a system level as part of our Better Care Plans.

Whilst the CCG will continue to focus on ensuring our mental health services deliver the best possible outcomes; moving forwards the strategic approach will be to broaden our approach in line with the national strategy No Health Without Mental Health and the Better Care Plans During 2013 the CCG in partnership with Brighton and Hove Council have developed a Happiness Strategy: a three year Mental Health and Wellbeing Strategy for the City that will be implemented from 2014-15 onwards. The Strategy takes an all-round approach covering prevention of mental ill health, promotion of happiness and wellbeing as well as the development of services that are specifically shaped and commissioned for mental health. The CCG have worked collaboratively with the City Council to look in the widest way possible to bring together resources and ideas and support for improving the mental health and wellbeing of our residents. We have looked to arts and culture, to gardening, to cooking and eating, to sports and walking and everything in between. This broader approach aims to support the mainstreaming of mental health and wellbeing into all parts of the CCG's and BHCC's business as well as the community. By making the promotion of mental wellbeing part of everyone's business we anticipate it will help reduce some of the stigma associated with mental health.

Delivering a sustainable health system

Deliver a sustainable health system by ensuring our clinical care models, commissioning and procurement processes and internal business practices reflect the broader sustainability agenda and deliver on our duties under the Social Value Act.

See chapter 4: Enablers, Page 28 & 29.

Fit for caring, fit for sharing

Exploit opportunities provided by technology to deliver truly integrated digital care records, derived from the GP Record as the primary source which will be made 'Fit for caring, fit for sharing' through a programme of information management and data quality initiative

The CCG Informatics Strategy sets out how the CCG will realise the enormous potential benefits of information to improve patient safety, outcomes and experience, reduce inequalities and improve efficiency by ensuring that high quality integrated information is available where and when required to support good decision-making by clinicians, patients and managers. The diagram below illustrates the CCGs vision for informatics:

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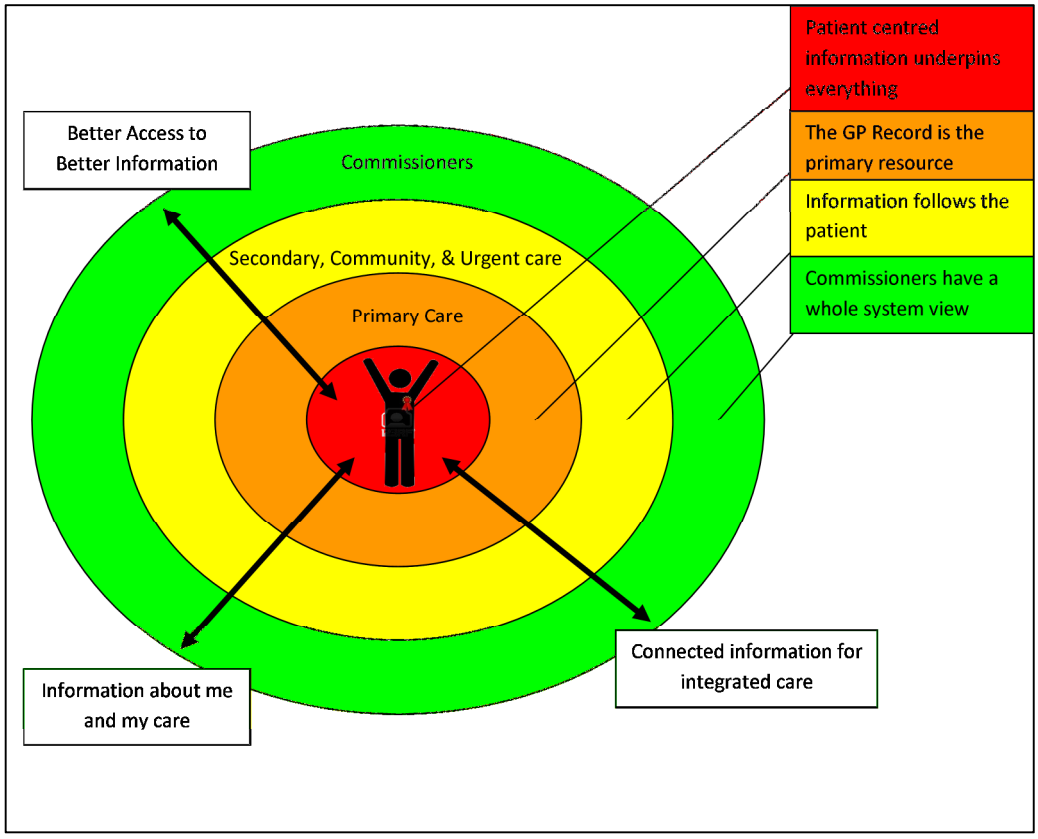


Figure 4: Informatics Vision

The CCG Informatics Strategy defines a number of key strategic areas and identifies the key requirements of each (see below). The CCG 2 year Operating Plan sets out in detail how the key requirements will be delivered.

Keeping our local population healthy:

- Information for patients to support lifestyle choices.
- Integration and analysis of clinical data across care boundaries to provide information about effectiveness of care pathway provision

- Information for commissioners to identify health needs and inequalities.

Providing accessible care.

- Information to signpost patients to most appropriate service choices.
- Information about patients is available where and when required to support scheduled and unscheduled care.
- Information to signpost professionals to most appropriate service choices.
- Information to support planning and commissioning

Providing high quality care

- Patients have access to information about their health and care to enable them to be pro-active partners in care. Integrated clinical records which support continuity of care and avoid unnecessary and inappropriate interventions.
- Managers, commissioners and planners have access to good quality, relevant information which shows outcomes across care pathways

Involving patients and the public

- Patients should have improved options for communicating with clinicians and commissioners
- Integrated information is needed to produce outcome information for patients about the whole care pathway.
- Patients and the public have access to good quality information about the performance of services as well as information about their own health and care.

We will offer on-line tools and services that support personalisation. We will harness the power of the digital revolution, web tools and apps to make this a reality. We will use the lessons learnt from the local pilot project to help those people with long term conditions to use the internet and health applications to improve their health along with the outcomes from the Tinder Foundation Health Literacy Programme to help shape and refine this programme of work.

Chapter 4: Enabling Strategies

Quality Improvement Plans

Brighton & Hove published its response to the Francis report and recommendations in July 2013. As a commissioning organisation the key recommendations requiring focus were identified and an analysis against our values, practice and processes was undertaken.

Subsequently three further papers were published.

- Berwick: A Promise to Learn – A commitment to Act.
- Professor B Keogh - Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report.
- The Governments full response to the Francis Report, *Hard Truths – the journey to putting patients first*.

On publication of these three further documents Brighton & Hove CCG has taken the opportunity to revisit its original response to the findings of initial reports stemming from the Mid Staffordshire enquiry. This aimed to ensure that we have inclusively considered and acted upon the learning of these further publications, to support the organisations responsibility and accountability to commission and monitor high quality, safe and effective services in collaboration with the citizens of Brighton & Hove.

The organisation has made a commitment to continuous improvement, taking every opportunity to learn from evidence identified in reviews. We believe that we have structures and processes in place which support us to respond in a timely and flexible way to evidence from our own internal monitoring and audit, that from other organisations and from National findings. That we are building relationships with our providers based on honesty, openness and transparency and which is inclusively involving partners and citizens in the development and review of service development. The CCGs 2 year Operating Plan sets out in detail how we will ensure quality improvements in all services we commission.

Equality

We are committed to meeting our legal and moral responsibilities in relation to promoting equality, eliminating discrimination and promoting good relations between individuals and communities.

We will make sure that our commissioning meets our obligations under the Public Sector Equality Duty and the objectives in the CCG Equality and Diversity Strategy by:

- engaging and involving our population, specific communities of interest and other stakeholders;
- reviewing the provision of, and access to, services; and
- undertaking equality assessments to ensure the services we commission are accessible, effective and appropriate for our diverse communities.

Last year Brighton and Hove CCG used the Equality Delivery System to review and improve its performance in respect of people sharing characteristics protected by the Equality Act 2010. The CCG found this a useful process in identifying the steps that it needs to take to en-

sure that it carries out its business in a way that reaches all of the city's groups. Going in to its second year of operation the CCG is looking forward to repeating this process with the revised EDS2 and updating our actions and equality objectives as necessary.

Co-ordinating Commissioner Role

Brighton and Hove CCG are the co-ordinating commissioner for Brighton and Sussex University Hospital Trust (BSUH and act on behalf of all other CCGs in Sussex to commission services from BSUH. The Co-ordinating Commissioner is responsible for the day to day management of the Main Contract and are responsible for the following functions:

- To provide an overview to the procurement, review and performance planning and management of services, to meet the health needs of CCGs' populations. However, each CCG will remain responsible for the strategic planning and commissioning of services for its local population.
- To ensure that Services provided under the contract with the Provider and any other agreed services are provided to the highest clinical standard, represent value for money and meet the access requirements of the population served for all of the CCGs.
- To oversee the monitoring of Provider wide activity and financial performance for services and other agreed services and develop additional financial arrangements (e.g. additional funding above Payment by Results tariffs, end of year financial agreements, suspension of Payment by Results etc.) where agreed by the CCGs.

The provision of local hospital services will change significantly over the next 5-10 years due in part to the commissioners intentions to move activity away from acute services to community settings but also because the local acute Trust Brighton and Sussex University Hospital Trust (BSUH) will be undertaking a radical capital project during the same period.

The 3Ts project (teaching, trauma and tertiary project) has four key elements within it:

Stage 1 – will replace the wards and departments in the Barry Building, allow the full transfer of the regional neurosciences service from Haywards Heath and provide the full range of facilities to support the Major Trauma Centre in fit for purpose accommodation. The current wards in the Barry Building were built 20 years before Florence Nightingale became a nurse and at least 30 years before she wrote "Notes on Hospitals" which has guided hospital design since. There are currently only 5% of single bedrooms in the Barry and Jubilee buildings. The number of bathrooms and toilets is also inadequate. In the Barry Building the ratio is one toilet to four patients; in the 3Ts development this will be one toilet per 1.7 patients in the medical and elderly wards whilst all the single rooms will have en suite toilets/bathrooms.

Helipad and Energy Centre – this will provide a helipad on the Thomas Kemp Tower and a new energy centre for the hospital site which will be much more energy efficient;

Stage 2 – this replaces and expands the Sussex Cancer Centre and provides additional facilities for teaching and research.

Stage 3 – a Facilities Management and logistics centre to serve the whole site. This is for receipt and distribution of supplies, waste etc

Even though the name of the programme is 3Ts (teaching, trauma and tertiary care), this does

not necessarily do justice to the significant element of the redevelopment which relates to District General Hospital Services.

During the construction phase a process of decanting will take place i.e. moving departments into temporary (or permanent) locations to allow the main construction project to take place;
The process of planning new locations for has been clinically led and in accordance with the following key principles:

- There will be no reduction in service to patients – no service will be stopped whilst the main 3Ts construction is going on;
- Patient access has been prioritised;
- Improved patient environment, with better facilities for patients than in the current facilities,
- Maintain clinical adjacencies between department within the hospital;
- Wherever possible, patient departments (and all others) should only move once before moving finally into the main 3Ts build to minimise disruption to services.

The CCG is fully supportive of the 3Ts project as co-ordinating commissioner the CCG has a duty to ensure the continuity of services during the construction phase without a reduction in quality or increased risk to patient safety. The CCG will undertake a rigorous assurance process on behalf of the local population but also on behalf of all other patients that attend BSUH.

Social Value and Procurement

The Public Services (Social Value) Act of 2012 came into full effect on 31 January 2013. The Act, for the first time, places a duty on public bodies to consider social value in procurement and related activities. In commissioning services, public bodies now need to consider how procurements will add value and improve the broader economic, social and environmental wellbeing of the area.

Ensuring value for money in public service delivery is now a more pressing policy concern than ever before. Measures of social value - which take into account a broader understanding of the benefits to society from how a service is delivered - are increasingly being considered alongside traditional criteria such as financial value as commissioners seek ever more impact for every pound of public money spent.

When social value is considered it not only maximises the impact of our commissioning decisions on the health and wellbeing of our population but it can also help to level the playing field for potential providers such as NHS providers, third sector organisations, charities and social enterprises as they often have elements of social value hard wired into them.

In fully utilising the opportunities presented by the Act, Public Bodies can help enable local communities to become more resilient and reduce demand on public services through opportunities for skills development and training, reduced unemployment, increased standards of living, reduced isolation, greater self care etc – as long as they as proportionate and relevant to the service or local area.

We are committed that from the outset of commissioning and procurement processes to co-design services with patients and the public and build elements of social value into our care

pathways and service specifications. We will to communicate a clear and unambiguous message about our intention to include social value in our procurement methodology whenever we communicate with the market and to incorporate measures of social value in our evaluation of bids and resulting contracts.

In particular we will ensure that our service re-design and procurement processes:

- Consider specific and relevant elements of added social value when developing service specs.
- When announcing our intention to procure services to make reference to our expectation that potential providers will demonstrate outcomes related to social value.
- Provide further explanation in PQQ documentation so that all bidders are clear about the importance of demonstrating added social value in their tender bids.
- include a dedicated (and appropriately weighted) section within evaluation criteria that addresses the added social value of potential providers. The criteria needs to be proportionate and linked to the subject matter of the contract.
- Insure contracts placed with providers as a result of procurement processes have elements of social value embedded in them and form part of the performance monitoring requirements.

The CCG Procurement Strategy sets out how the CCG intends to procure goods and services, across the whole spectrum of purchases it makes, to deliver good value for money and to support effective commissioning, as well as meeting legal and regulatory requirements.

Sussex Armed Forces Network

The Armed Forces plans have been developed for and owned by all Sussex CCGs. The key stakeholders who have developed the plan are the Sussex Armed Forces Network which is accountable to the Sussex CCGs Strategic Clinical Executive Commissioning Committee where the seven Sussex CCGs meet strategically in line with an agreed memorandum of understanding.

The Sussex Armed Forces Network (SAFN) is a multi-organisational group which includes members from the NHS, MoD, Armed Forces Reservists, Mental and Physical Health Clinicians, the Royal British Legion and other interested charities and organisations from across Sussex (i.e. police and local authorities).

The Armed Forces plan states the following vision: Sussex Community is better facilitated to provide the excellent support to the Armed Forces Community across Sussex. Those who served in the Armed Forces whether Regular or Reserve, those who have served in the past and their families, should face no disadvantage and receive the integrated care and support they require tailored to their particular needs in accordance with the Armed Forces Covenant.
The Desired State in 2018/19

- Public and members of the NHS have an awareness of issues affecting personnel, veterans and families.
- Clear integrated pathways for transitioning Armed Forces personnel into civilian life.

- There is early identification and referral to the appropriate person, service and place to receive integrated care (including mental health) and support the Armed Forces Community require.
- Employers support their employees as reservists throughout the organisation ensuring their health and wellbeing.

Improved Quality and Outcomes

- Through the development of services, training and development and agreed pathways access to mental health services by veterans/reservists and families are available to the standards required, when and where they are needed.
- Through effective integrated pathways the transition of those who have been seriously injured in the course of their duty, or leave for other reasons is streamlined and continuous.
- Through the development of communicated options of pathways, equality and ease of access for armed services personnel/veterans and their families to the services they need.
- Through effective communication, collaboration, training and development of all partners' within Sussex there is increase awareness of the needs of the Armed Forces Community resulting in appropriate integrated care.

Chapter 5: Outcomes and Resources

Measurable Outcome ambitions

There are seven key outcomes which our plans are aligned to and against five of which we have set measurable targets. The table below sets out the outcomes, the current position and where we hope to be in 5 years' time. Detailed trajectories for each of ambition are contained in Appendix 4.

Outcome Ambition	Current state	End state ambition
1. Securing additional years of life for the people of England with treatable mental and physical health conditions	CCG is currently in the 3rd best national quintile for PYLL. The minimum reduction required is 3.2%.	the CCG has set an ambition to reach 11%reduction by 2018/19 (subject to clarification following the PPMA)
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	CCG is currently in the 3rd best national quintile for this measure. Improvement between 2011/12 and 2012/13 was 1%	CCG has set a trajectory based on continued delivery of a 1% increase per year. This would move the CCG up a quintile by 2018/19
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	The CCG reduced emergency admissions by 3% between 2010 and 2011 and a further 3% between 2011 and 2012. This has maintained our position in the 2nd best national quintile	Our QIPP plans forecast a further reduction of 4% in 2014/15 and 3% in 2015/16. Delivery of this level of reduction would move us to best quintile performance. The CCG has set a trajectory to maintain best quintile performance.
4. Increasing the proportion of older people living independently at home following discharge from hospital	No CCG indicator currently available	n/a
5. Increasing the number of people having a positive experience of hospital care	The CCG is currently in the best quintile for this measure	The CCG has set a target to maintain best quintile performance.
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	The CCG is in the 3rd best national quintile for this measure.	The CCG plans place particular emphasis on the shift from acute care to community and primary care therefore the CCG has set a level of ambition to achieve year on year improvements over the next 5 years.
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	No CCG indicator currently available	n/a

Financial Sustainability

The CCG financial plans comply with the financial framework and are contained in Appendix 2.

The CCG has maintained a carry forward surplus at £14.5m (4%) in 2014/15. This will drop to 2.5% c£9m in 2015/16 and then over the 5 year period ultimately down to 1.5%. The CCG will keep plans under review, seeking to make additional 'invest to save' plans if possible and bring forward savings.

The plans are reasonably complete for 2014/15 including responding to the central request to increase our planned surplus. Application of funds in 2014/15 is aimed at delivering significant savings in 2015/16 and 2016/17. These are mainly to release funds to add to the Better Care Fund (£10.4m).

The Better Care Fund is being established in part using monies from the 2.5% non-recurrent expenditure fund within the CCG in 2014/15 to release savings in 2015/16 and 2016/17. By 2015/16 the fund should stand at £19.7m. £8.1m is already being spent on integration schemes.

As well as the risks in the deployment of the BCF not having the planned impact on improving outcomes and moving care to an appropriate setting there are financial risks and risks with the 2014/15 investments being made to enable the release of the £10.3m from hospital services. If these schemes do not have the planned impact it will restrict the availability of funds in 2015/16. This will therefore spread the deployment of the BCF into 2016/17.

The CCG has built up a fund as recommended nationally to ensure that it moves from 2013/14 into 2014/15 in the strongest position it can be in. This gives the Brighton health and social care system the ability to be ambitious with its transformational schemes and realistic in terms of the profile of both investments and savings.

The table below shows the financial impact (£'000) by health sector and reflects our plans to reduce acute spend and invest in community and primary care services. Over the five year period we plan to reduce acute spend by ~£21m and increase community and primary care spend by ~£14m and ~£13 respectively:

	14/15 Plan	15/16 Plan	16/17 Plan	17/18 Plan	18/19 Plan	Net Change
Acute	(3,825)	(4,345)	(4,485)	(3,902)	(4,192)	(20,749)
Mental Health	396	500	650	825	850	3,221
Community	3,166	3,657	2,500	2,000	1,750	13,073
Continuing Health Care	2,870	3,695	1,531	1,622	1,718	11,436
Primary Care	2,539	3,044	3,193	3,428	3,681	15,885

Chapter 6: Governance and Risks

Governance Overview

The CCG will at all times observe the generally accepted principles of good governance in the way it conducts its business. These include:

- the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- The Good Governance Standard for Public Services;
- the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles';
- the seven key principles of the NHS Constitution;
- the Equality Act 2010; and
- the Standards for Members of NHS Boards and Governing Bodies in England.

Our governing body has four main tasks:

- ensuring effective delivery of strategy and planning;
- accountability;
- systems of control; and
- establishing and promoting public sector values and high standards of conduct.

Each member of the governing body shares responsibility for delivering these functions effectively, efficiently and economically in line with our governance framework.

The following established committees are accountable to the Governing Body:

a) Audit Committee;
b) Remuneration and Nominations Committee;
c) Operational Leadership Team;
d) Clinical Strategy Group; and
e) Quality and Assurance Committee,

Details of the roles and responsibilities of each of the committees is contained within the CCG Constitution.

Brighton and Hove City Health and Wellbeing Board

Brighton and Hove is covered by one City Council and one Clinical Commissioning Group, making the relationship between these two organisations rather more straightforward than in some other areas. Brighton and Hove City Council and local NHS commissioners and providers have a long and successful history of partnership working reflected in formally shared services and informal partnership working, complemented by a well-established and thriving strategic partnership structure across city organisations including the police, fire service, academic institutions, local businesses and third sector organisations.

Health and Wellbeing Boards are tasked with ensuring fully integrated health and social care

commissioning strategies for their area. These strategies should reflect both the Joint Strategic Needs Assessment for the area and an agreed Joint Health and Well Being Strategy.

Measuring success - governance and performance management

The CCG takes a robust, proactive approach to measuring and monitoring of plans and the associated outcomes, using programme management to monitor and oversee CCG performance and delivery. Further details of our programme management office and risk management are contained in our Operating Plan.

Better Care Fund Governance

Brighton and Hove CCG and Brighton and Hove City Council already have well-established joint commissioning and partnership arrangements which provides a solid foundation to develop further integration of care. However, it is recognised that the Better Care programmes of work will require both an acceleration of pace and a more transformational and innovative approach to deliver improved outcomes within the required timescales.

A Better Care Programme Board has been established to oversee the Better Care work programmes. Its main purpose is to provide system wide leadership and accountability for delivery of the Better Care Agenda across Brighton and Hove health and care economy. Overseeing the work of the various Integration Programme Boards the Better Care Programme Board will ensure the vision and requirements of Better Care are implemented. The Brighton Better Care Programme Board is accountable to the Brighton and Hove Health and Wellbeing Board. Integrated Programme Boards for Frailty as well as specific Board for Homeless will report in to the Better Care Programme Board. Whole System Enabling Work-streams for IM&T, HR, communication, engagement and Finance will support the overall programme.

Principal Risks

The CCG Risk Policy and Strategy outlines our approach to risk management and our assurance framework describes the assurance process and risk appetite of the organisation.
In December 2013 the Governing Body held a seminar which looked at principal risks to delivery of the strategic vision. The table below summarises the risks identified:

Risk Description	Severity	Likelihood	Total	Actions	Residual Rating
There is a risk that the workforce and resource required within primary and community care to deliver the transformational change will not be available. This could result in less activity moving from acute to community care and result in a cost pressure for the CCG.	3	4	12	Working with Kent Surrey Sussex (KSS) Health Education England (HEE) pilot to develop a multi-professional ethos of education in primary care.	6
There is a risk that changes to the urgent care pathway will not sufficiently reduce non elective admissions resulting in an over-performance against the contract and poor patient experience.	3	4	12	Refresh of Urgent Care Plan in collaboration with the Trust, LA, SECAMB and other CCGs during summer 2014.	6
There is a risk that the results of the PPMA will result in increased workload in primary care. The resource may not be sufficient to deliver the audit outcomes and therefore could have a detrimental effect on the plan to reduce health inequalities in city.	3	4	12	Develop Primary Care Strategy and Workforce Plan with members and partners during summer 2014	9
There is a risk that integration of physical and mental health services for existing services may not be implemented within the ambitious timetable set out in the plan.	3	3	9	Strengthen role of HWB to oversee process. Ensure internal resource is aligned to transformational work streams.	6
There is a risk that the organisation or neighbouring CCGs will not be sustainable following the proposed reduction in running costs	3	3	9	The CCG is committed to developing a Sustainable Commissioning Plan and will work with neighbouring CCGs to agree additional collaboration or increased use of CSUs if required.	6
There is a risk that the pace and scale of technological required to enable the delivery of the system vision is not deliverable within the given resource.	3	2	6	The CCG has included a significant IM&T work stream with associated funding in its BCF bid.	4

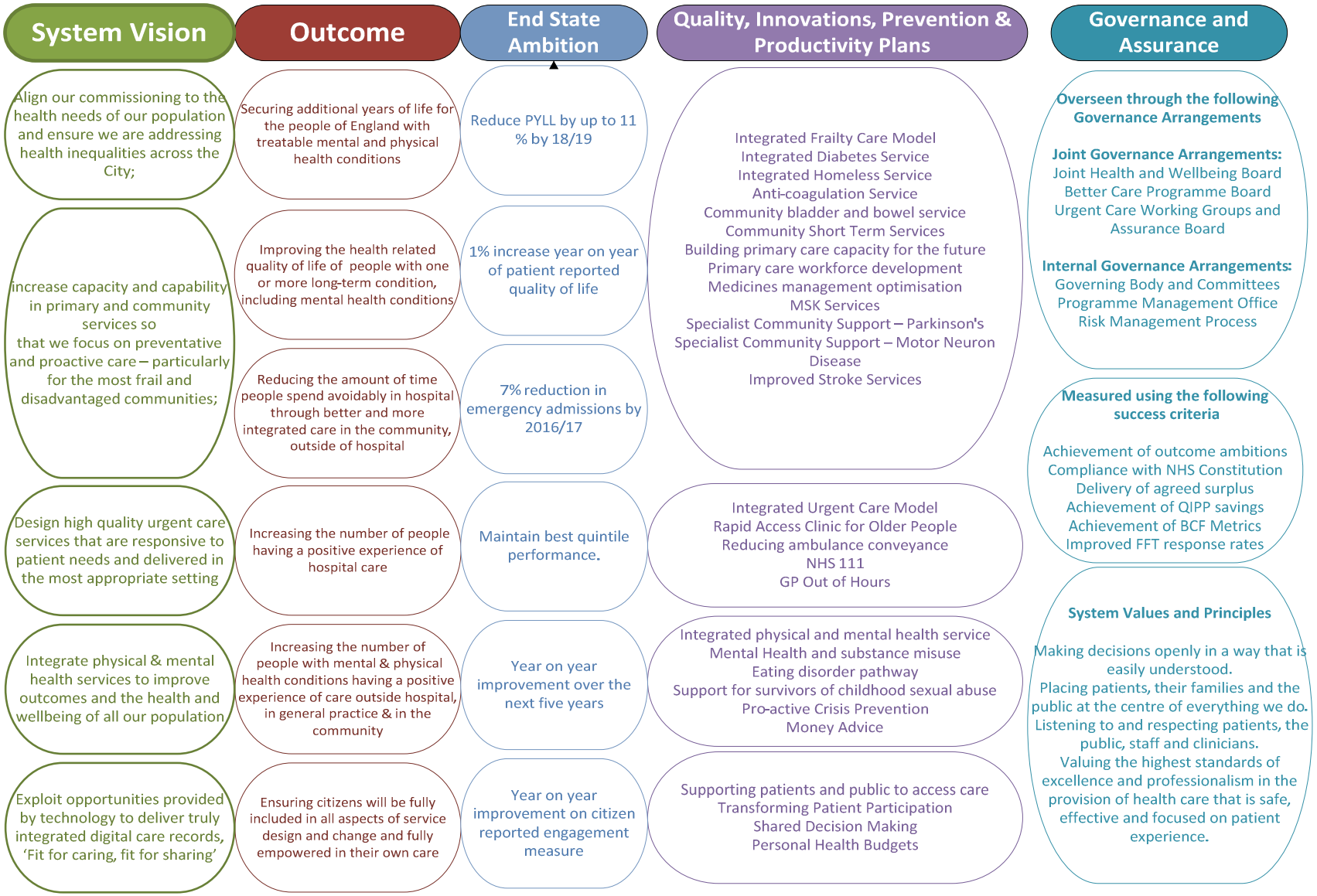
Conclusion

Our CCG Strategic Commissioning Plan for 2014-2019 demonstrates our dedication, and outlines the drivers and mechanisms, through which the CCG and its partners will ensure collaboratively planned, seamlessly delivered, ever improving, carefully monitored and continually assured healthcare services that meet the needs and priorities of local people.

Glossary

BSUH	Brighton and Sussex University Hospital Trust
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRRS	Community Rapid Response Service
CSG	Clinical Strategy Group
CSU	Commissioning Support Unit
DES	Direct Enhanced Service
GP	General Practitioner
HCAI	Health Care Acquired Infection
IAPT	Improved Access to Psychological Therapies
JHWB	Joint Health and Wellbeing Board
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LES	Local Enhanced Service
LMG	Local Member Group
LTC	Long Term Conditions
MDT	Multi-disciplinary Team
MSK	Musculoskeletal
NICE	National Institute for Health and Clinical Excellence
OOH	Out of Hours
PBR	Payment by Results
PH	Public Health
PPG	Patient Participation Group
PRH	Princess Royal Hospital
PROMS	Patient recorded outcome measures
PSED	Public Sector Equality Duty
QAC	Quality Assurance Committee
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality Outcome Framework
RACOP	Rapid Access Assessment Clinic for Older People
RACH	Royal Alexandra Children's Hospital
RSCH	Royal Sussex County Hospital
RTT	Referral to Treatment Time
SCT	Sussex Community Trust
SIRI	Serious Incident Requiring Investigation
SPFT	Sussex Partnership Foundation Trust

Appendix 1 – Plan on a Page



Appendix 2 – Finance Schedule

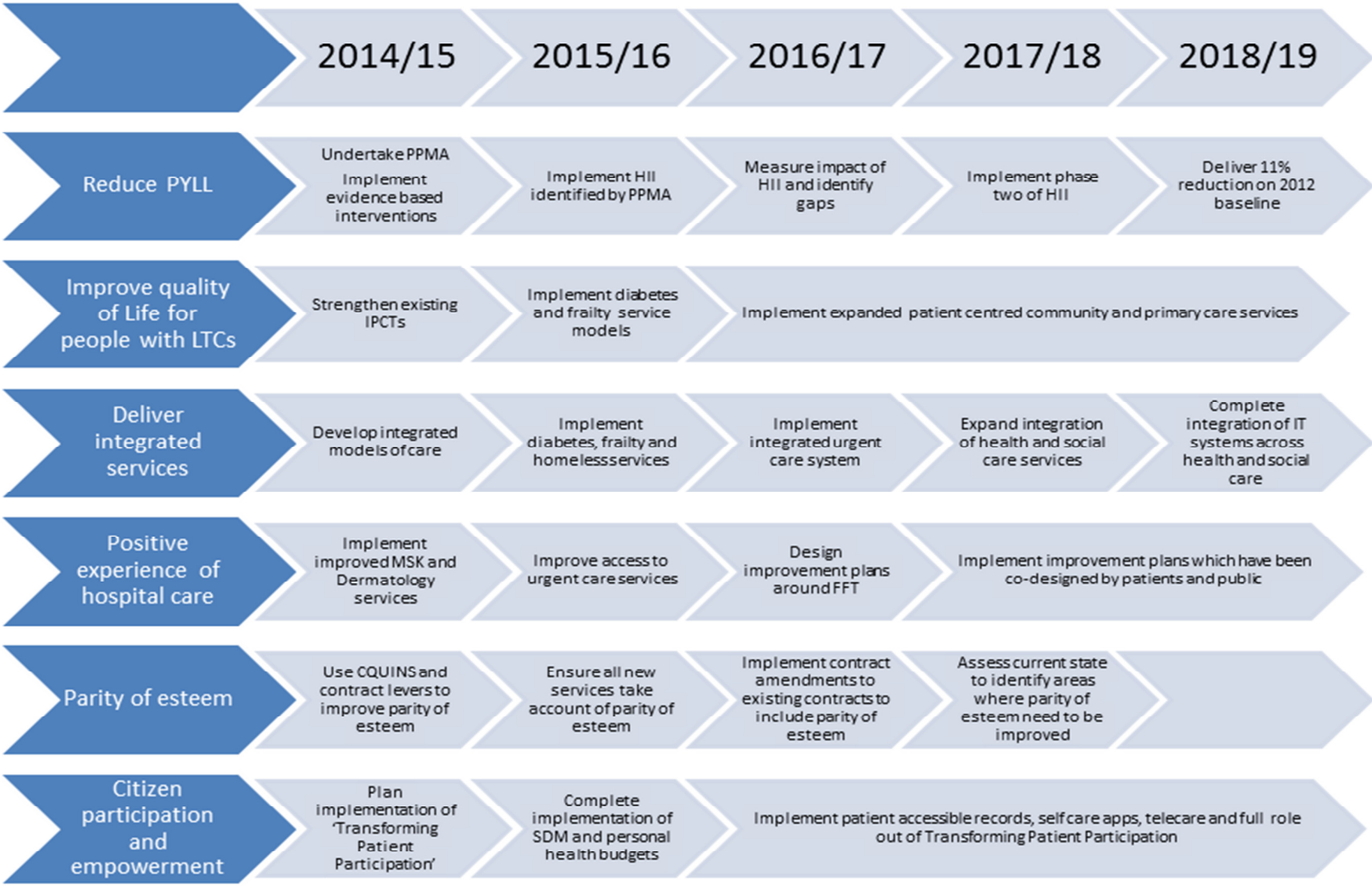
	14/15	15/16	16/17	17/18	18/19
	£'000's	£'000's	£'000's	£'000's	£'000's
Allocation Growth	7,264	5,869	6,429	6,175	6,280
Allocation Total	339,456	345,239	357,185	363,257	369,433

	14/15	15/16	16/17	17/18	18/19
% Allocation Growth	2.14%	1.70%	1.80%	1.70%	1.70%
Tariff Deflator (Acute)	-1.50%	-1.60%	0.40%	-0.60%	-0.70%
Tariff Deflator (Non-Acute)	-1.80%	-1.80%	-1.00%	-0.60%	-0.60%
Activity Growth	2.35%	2.35%	2.35%	2.35%	2.35%
CQUIN	2.50%	2.50%	2.50%	2.50%	2.50%
Prescribing Inflation	5.00%	5.00%	5.00%	5.00%	5.00%
CHC Inflation	3.50%	3.50%	3.50%	3.50%	3.50%
Contingency	0.50%	0.50%	0.50%	0.50%	0.50%
BCF (Estimate)	0.00%	3.00%	0.00%	0.00%	0.00%
Non-Recurrent Expenditure Reserve	2.50%	2.00%	2.00%	2.00%	2.00%
Planned Surplus	3.50%	2.50%	2.00%	1.50%	1.50%

	14/15	15/16	16/17	17/18	18/19
	£'000's	£'000's	£'000's	£'000's	£'000's
Growth	7,264	5,869	6,429	6,175	6,280
Return of Prior Year Surplus	5,269	14,556	9,294	7,456	5,655
Additional Surplus	6,969	-	-	-	-
QIPP & Efficiency Savings	5,955	8,888	3,951	4,413	5,036
Total Funding Available	**25,457**	**29,313**	**19,674**	**18,044**	**16,972**
Cost Pressures	4,753	2,000	3,500	3,500	2,000
Growth / Inflation / Tariff / CQUIN	4,354	5,803	6,855	7,004	7,344
Primary Care - Care of Older People (£5pph)	-	-	-	-	-
Contingency	1,794	1,859	1,864	1,885	1,907
BCF (Estimate)	-	10,357	-	-	-
Top Up Non-Rec Expenditure Reserve	-	-	-	-	-
Planned Surplus	14,556	9,294	7,456	5,655	5,720
Total Funds Utilised	**25,457**	**29,313**	**19,674**	**18,044**	**16,972**

2% Non-Rec Expenditure Reserve	**8,486**	**6,905**	**7,144**	**7,265**	**7,389**

Appendix 3 – Milestone Plan



Appendix 4 – Outcome Ambition Trajectories

Outcome Ambition	Measure	2012 Baseline	Target 2014/15	Target 2015/16	Target 2016/17	Target 2017/18	Target 2018/19	Trajecory
1. Securing additional years of life for the people of England with treatable mental and physical health conditions	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare per 100,000 population	2141.3	2091.62	2041.94	1992.26	1942.58	1892.9	
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	Average health status (EQ-5D) score for individuals who identify themselves as having a long-term condition	73.5	74.24	74.98	75.73	76.48	77.25	
3. redcuing emeregency admissions	- Emergency admissions for acute conditions that should not usually require hospital admission.	1772.6	1683.97	1666.244	1648.518	1630.792	1595.34	
4. Increasing the proportion of older people living independently at home following discharge from hospital	No indicator available at CCG level	-	-	-	-	-	-	-
5. Increasing the number of people having a positive experience of hospital care	Rate of survey responses of a 'poor' experience of inpatient care per 100 patients	129.9	129.9	129.9	129.9	129.9	129.9	
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Poor patient experience of primary care in GP services and GP out-of-hours services	5.9	5.72	5.54	5.36	5.18	5	
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	No indicator available at CCG level	-	-	-	-	-	-	-