NHS
Brighton and Hove
Clinical Commissioning Group

‘Caring Together’ Programme Description

17 March 2017

VERSION 2.0

Foreword

Brighton & Hove's 'Caring Together' Programme is not simply another centrally-mandated initiative to change how care providers operate; nor just the latest in a long line of partial reorganisations of components of the health and care economy. What it represents is a fundamental reimagining of our local health and care environment. This is a challenge to us all to be bold and an opportunity to commission and provide truly modern services for our City in difficult times.

Caring Together requires us all to question how we deliver health and social care in Brighton and Hove: it will ask us all to reflect on how we respond to the quantity and complexity of rising demand and how we manage a shrinking real-terms budget that requires us all to be a part of the change. 'Caring Together' provides us with a once-in-a-generation opportunity to put in place a framework for care delivery that sustains the services we all care about and ensures they are available to future generations, as they have been to those of us fortunate enough to have benefitted from them up to now.

There is little doubt that the health and social care environment that we face is extremely challenging. Demand for services is rising faster than funding can keep pace and the complexity of patient and service user conditions increases as communities are challenged, and people live longer and require more integrated support in older age.

In recent years, the Better Care Fund has been a significant driver of the integration agenda and in looking to protect funding for social care services but the increasing demand and the funding challenges we face mean that we must do more and do it quickly. Commissioners and providers recognise this and we have all signed up to this programme to ensure that we can continue to provide high quality services and value-for-money to the residents of our City.

'Caring Together' is a programme of transformation for Brighton & Hove but it also serves as our response to the Sussex and East Surrey Sustainability and Transformation Plan (STP) and the local sub-footprint of the Central Sussex and East Surrey Alliance (CSESA). While we are committed to supporting the delivery of the STP, our focus will always be on delivering the right solutions for Brighton & Hove and that is why 'Caring Together' is so important to get right.

This is an ambitious and critical programme of transformational change that will be co-designed and delivered only with the full engagement of our partners: commissioners, providers, the voluntary sector and the public.

It will require everyone involved in health and care in Brighton & Hove to be ready to face the challenge.

Dr David Supple, Chair of Brighton & Hove Clinical Commissioning Group
Adam Doyle, Accountable Officer of Brighton & Hove Clinical Commissioning Group

Cllr Daniel Yates, Chair of Health and Wellbeing Board
Geoff Raw, Chief Executive of Brighton & Hove City Council

1. Introduction and Context

The case for transformational change on the scale of 'Caring Together' is made both nationally and locally.

1.1 The NHS nationally

Nationally, some statistics around the rapidly changing landscape were highlighted by The King's Fund on 20 December 2016[1]:

- Between 2003/04 and 2015/16, admissions to hospital in England have increased by 65% while the population has risen over the same period by 9.7%[2]. This means that hospital admissions have grown by a factor of 6.7 above population growth.
- In the first quarter of 2016/17, 9.7 per cent of patients spent longer than four hours in A&E, the highest level at the time of year since 2003/4
- At the end of June 2016, 6,100 patients were medically fit to leave hospital but still awaiting discharge; the highest number since data collection began and an increase of 22 per cent on June 2015.
- The total elective waiting list of patients continues to grow, with an estimated 3.8 million patients waiting for treatment in June 2016; the highest level since December 2007.
- Nearly half (47 per cent) of NHS trusts forecasting end-of-year deficits and only a third confident of meeting the control totals they have agreed with NHS Improvement.
- Total referrals to outpatient services (combining referrals from GPs and from other sources, such as A&E departments or consultants in other specialties) increased from 3.6 million in Q1 2003/4 to 5.8 million in Q1 2016/17, an overall increase of 62%.
- Referrals from GPs specifically have increased from 2.4 million in Q1 2003/4 to 3.6 million in Q1 2016/17, an overall increase of 51 per cent.
- This growth in referrals from other sources represents an overall increase of 85 per cent, and an average rate of increase of 4.8 per cent per year.
- Between 2003/04 and 2015/16, the number of people aged over 85 has increased by nearly 40 per cent.

Against the evidence of the rising demand, set out above, falling funding levels in real terms in the NHS presents its own problems:

- Until 2010/11, spending rose at an average rate of 4.8 per cent per year, generally faster than admissions. However, between 2010/11 and 2014/15, funding slowed significantly, averaging 1.2 per cent per year, and is set to average 1.1 per cent per year from 2015/16 until 2020/21, considerably lower than the average for the whole period.
- NHS providers ended 2015/16 with a record deficit of £2.45 billion.[3]

Given the growing gap between activity and funding, the King's Fund analysis highlights the importance of finding ways to moderate demand for hospital care. It

[1] https://www.kingsfund.org.uk/publications/hospital-activity-funding-changes

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/timeseries/enpop/pop

[3] https://improvement.nhs.uk/news-alerts/nhs-providers-working-hard-still-under-pressure/

argues that the best hope for this lies in strengthening community services by building on the new ways of delivering care being developed under the Forward View.

Chris Ham, Chief Executive of The King's Fund, said, ''With the gap between funding and hospital activity set to grow over the next few years, the NHS needs to do everything it can to moderate demand for hospital care. We know that some of this demand can be avoided if alternative services are available – the challenge is to provide the right care in the right place at the right time and to ensure hospitals are only used when necessary and appropriate."

1.2 The national focus on social care

Councils' core government grant has reduced by 40% in real terms between 2010/11 and 2015/16 and there has been a 'flat cash' settlement for the remaining years of the decade, which means that any cost pressures arising during this period will have to be offset by further savings. Consequently, the Local Government Association (LGA) estimates that local government faces an overall funding gap of £5.8 billion by 2019/20.

The importance of social care to the overall health and care economy is clearly illustrated by the rising numbers of delayed transfers of care (DToCs) attributable to Social Care, which increased over the last year to 34.8% in November 2016, compared to 31.1% in November 2015.[4] Put another way, of the nearly 570,000 bed days lost to DToCs during Quarter Two of 2016/17, nearly 200,000 were directly attributable to problems arranging social care packages.

The previous Coalition Government launched the Better Care Fund (BCF) in June 2013, an ambitious programme with the ultimate aim of pooling £5.3m worth of local health and social care budgets to incentivise NHS and local government commissioners and providers to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems. By the latest 2016/17 BCF guidance, the increasingly prominent aim of 'protecting social care' had become one of the three objectives of the fund, in recognition of the funding challenges facing social care.

To partially overcome the financial gap caused by the flat rate settlement, the Government enabled local councils to raise a local Council Tax precept of 2% in 2015/16 and of 3% in 2016/17, although even these local taxes will only meet a proportion of the projected funding deficit. The Budget in March 2017 identified an additional £2bn funding for social care and, while this is welcome, it cannot be seen as the panacea for all the challenges facing social care nationally and, specifically, in Brighton & Hove.

Nationally, therefore, social care continues to face significant delivery challenges in the coming years against a background of rising demand for services. The need to find new ways of working are clearly as important for local authorities as they are for the NHS in the years to come.

[4] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2016/06/November-16-DTOC-SPN.pdf

2. Statement of Intent

In late 2016, NHS and Social Care commissioning and provider colleagues along with local community and voluntary sector stakeholders established the 'Caring Together' programme. Particular consideration was given to the ambition of the programme and the outcomes it should seek to achieve in light of:

- Local system challenges.
- NHS planning guidance requirement for every area to have an agreed plan in place for March 2017 for better integrating health and social care by 2020.
- Local authority devolution considerations.

As a result of these discussions, the following joint statement of intent was agreed for taking forward local integration as the Brighton and Hove Caring Together programme and signed by the leaders of the commissioner, provider and voluntary sector organisations:

"Our definition of integration is 'to commission for improvement in population outcomes and experience through the provision of coordinated care, organised around and responsive to the needs of individuals'.

- *The ambition for integration covers the whole population of Brighton and Hove. It will build from the progress achieved by the Better Care programme's focus on frail and vulnerable populations, and through a phased approach achieve whole population coverage and improved outcomes across the city.*
- *The scope of integration will cover both the commissioning and provision of prevention, care and support. It will include: adults and children's services, physical and mental health, social care, public health, primary care, community, and hospital services.*
- *Robust joint governance arrangements will be established to ensure that we have an effective partnership and transparent decision making to manage the integration programme that maximises the involvement of the community and voluntary sector, public and patients, and includes wider system partners in housing and education.*
- *A commitment to have a "one place, one budget" approach to our entire health and social care commissioning budget. We expect this to involve both a pooling of the health and social care budgets and a capitated approach to budget setting that enables providers to innovate and deliver agreed outcomes for the local population*
- *A commitment to establish robust and formal alliances that enable working across organisational arrangements to deliver fully integrated and personalised care and support, sharing both resources and risk for the benefits of citizens.*

"We will work together to deliver a programme of work that by 2020 achieves;

- *Sustainable, better quality health services*
- *Improved public health with fewer inequalities*
- *Support for vulnerable people to stay well outside hospital*
- *Empowered citizens and resilient communities who know where to get help and also how to help manage their own care and wellbeing."*

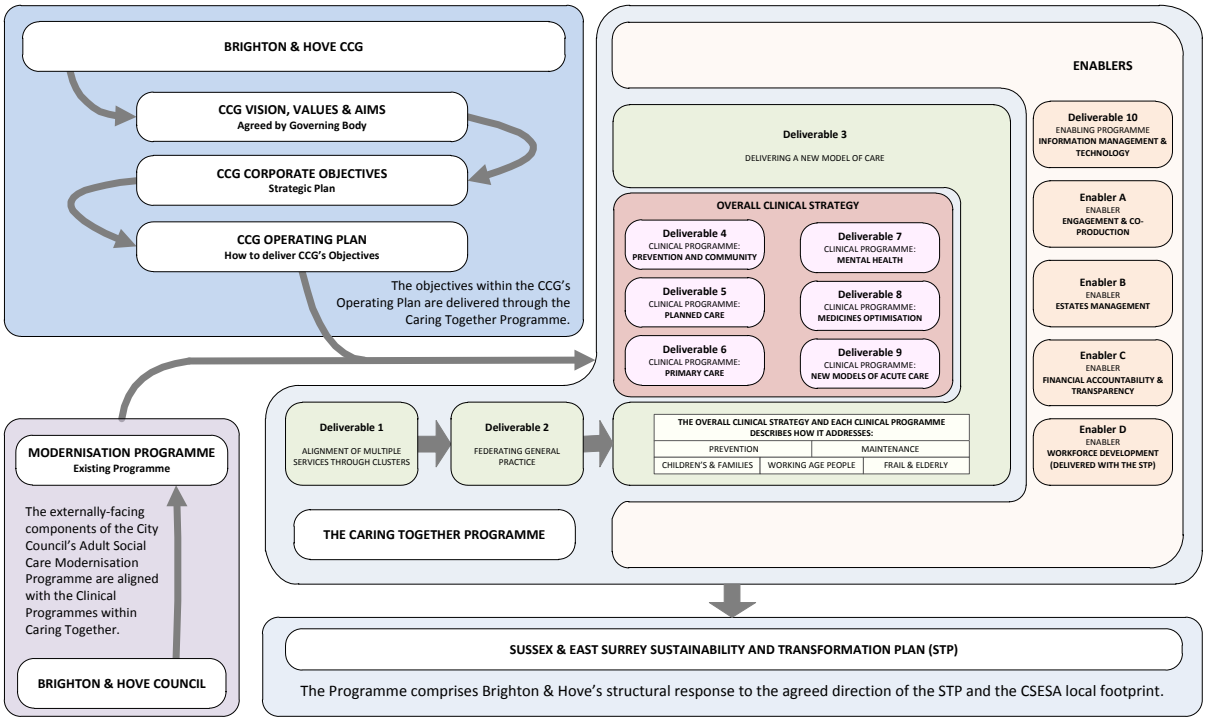
3. The Programme

'Caring Together' is a programme of delivery. It brings together a number of objectives from the partner organisations' own operational and delivery plans as well as responses to national and local transformation agendas.

The Programme delivers a significant number of outputs on behalf of the partners:

- It is the delivery programme for the CCG's Operating Plan 2017-19 and is informed by the corresponding CCG Corporate Objectives.
- It provides a delivery structure for the majority of the City Council's outward-facing outputs from its Adult Social Care Modernisation Plan.
- It comprises the Brighton and Hove response to the Sussex and East Surrey Sustainability and Transformation Plan (STP) and the local sub-footprint Central Sussex and East Surrey Alliance (CSESA).
- It aligns and controls the development, management, monitoring and evaluation of the CCG's QIPP delivery, as there will be a single, programme management process for all service redesign outputs within the CCG based on the components of QIPP, run through a formal PMO process.

Figure 1: How the programme delivers partners' outputs.



The Programme comprises six clinical programmes, four deliverable objectives and four enabling work streams:

- The first three non-clinical deliverables focus on the journey towards creating a new model of care and the establishment of new ways of working.
- There are six clinical programmes, the objective of which is to commission redesigned services that can be delivered through the new model of care. Each clinical programme is defined by a clinical strategy, which together comprise the CCG's overall Clinical Strategy.

- A fourth non-clinical objective provides a delivery framework for information management, data sharing and technology.
- The above are supported by four 'enabling work streams', delivered through the programme and, where appropriate, in partnership with the STP/CSESA.

The three non-clinical deliverable objectives on the journey to creating a new model of care are:

- Alignment of care teams in sustainable, co-terminous localities within the overall City area during 2017/18.
- Development of a contractible, federated Primary Care Services model for GP Practices operating as a legal entity by April 2018.
- A new model of care and new ways of delivering integrated services by the end of 2018/19.

A fourth non-clinical deliverable comprises a significant programme commitment in its own right. This is an enabling deliverable, 'Information Management and Technology', which delivers the outputs of the Local Digital Roadmap within the STP, as well as the broad information sharing objectives of all partners.

There are then six clinical programmes, each led by a Clinical Director and each of which will have its own clinical delivery strategy linked to the CCG's Operating Plan:

1. Prevention and Community Care.
2. Planned Care services to meet RTT.
3. Access to Primary Care and Urgent Care.
4. Equality of Access to Mental Health services.
5. Medicines Optimisation.
6. Future Models for Acute Care.

Each of the clinical programmes will separately address how it delivers both prevention schemes and supports maintenance of long-term conditions, as well as how it has a service impact separately on:

(a) children and families,

(b) working-age people; and

(c) the frail and the elderly.

The Programme is further supported by four enabling work streams:

- Meaningful Engagement and Co-Production: appropriate and accountable engagement and communication programme.
- Estates Development: a focused and resourced programme of estates development to support all the deliverables and clinical programmes.
- Financial Accountability and Transparency: commitment from partners to ensure a robust set of protocols around budgets, as well as assuming the s.75 Agreement responsibilities from the Better Care Fund Board.
- Workforce: to be delivered alongside the wider workforce development programmes within the STP/CSESA.

This is all explored further in the next section.

4. The Clinical Programmes comprising the Clinical Strategy

'Caring Together', as the title suggests, brings together commissioning partners in the CCG and City Council, as well as providers and the voluntary sector into a single programme.

The programme delivers the objectives of the CCG's Operating Plan 2017-19 as well as the externally-facing objectives of the City Council's Modernisation Programme and Commissioning Teams have invested a lot of effort in finding more focused ways of ensuring alignment between these objectives, as set out in the sections below. While the six functional programmes are described as 'Clinical Programmes', it must be remembered that this are also aligned to local authority objectives and the term 'clinical', which is convenient in healthcare terms, also refers to the delivery of all health and social care outputs within each programme.

Taken as a whole, these programmes comprise the CCG's Clinical Strategy, the inclusive focus of which demonstrates a whole-City approach to finding new ways of working within a model of care. Each of the Deliverables is explored in more detail in the subsequent sections and a prioritisation of activity is set out in section 22, below.

5. Deliverable 1: Alignment of care teams in sustainable, co-terminous clusters and localities

Over the past three years, general practice has worked to organise itself into six clusters, sometimes working across these boundaries in broader alliances with neighbouring clusters, with other providers and in delivering locally commissioned services. This way of working was established as part of the 'Proactive Care' programme that supported risk stratification of vulnerable patients through multi-disciplinary working and helped to create more sustainable ways of working across primary care; not just in general practice.

'Proactive Care' was a pilot that lasted for three years and is now in its final evaluation stage, having been extended for a final three months to the end of June 2017 to enable the evaluation to take place. The development of cluster working has been one of the undeniable benefits of the pilot and it is important that the Caring Together programme implements a way of developing that existing cluster working to ensure that the momentum and the good work continues and becomes an integral component in the way that primary care works in the City.

The programme will commence by taking the outputs of the Proactive Care pilot evaluation and quickly developing an approach to maintaining and progressing the beneficial outputs of the pilot. It is essential that the momentum gained in developing sustainable approaches to primary care in the City is not lost due to the end of the pilot and that commissioners act appropriately and creatively to find ways to support progress that has been made.

The overall objective of this deliverable is to work with the Local Medical Council (LMC) to reach a position where the whole of primary care in Brighton & Hove operates in sustainable and meaningful clusters or localities by the end of 2017/18. This will include the organisational form of finding new ways of working, as well as commissioning appropriate local services to be delivered through the new models.

It is envisaged that the enhanced cluster working will be the platform on which further federated working within general practice will evolve and that localised, joint working in this way will enable general practice to find ways to become more sustainable as it faces its own challenges, not least around workforce recruitment and retention, in the coming years.

5.1 Purpose:

The following describes the purpose of this deliverable:

- To ensure that primary care and all community service providers are aligned to deliver services efficiently and effectively within fit-for-purpose clustered arrangements, including aligning to the Social Care localities and integration of local authority OT services.
- To ensure that meaningful risk-stratification can take place in a multi-disciplinary context and that functions of the clinical programmes can operate at maximum efficiency.
- To support delivery the outputs of the GP Five Year Forward View for Brighton & Hove.
- To provide a framework within which practice variation improvement work can be delivered to ensure consistent delivery of services and outputs across general practice in the City.
- To provide a sustainable and consistent framework for the commissioning and uniform delivery of locally commissioned services.
- To support general practice to address challenges in respect of recruitment and retention within the City.
- To implement a formal framework that can be used by clusters and localities to recruit allied care staff across multiple practices.

5.2 Criteria for Success:

The following outputs are expected from this deliverable and will be used as the criteria by which successful delivery of the work will be measured:

- General practice and wider primary care operating in formally constituted clusters and localities, supported by social care and the voluntary sector.
- Continuing multi-disciplinary working to support risk-stratification.
- Reduction in practice variation.
- A new framework of locally commissioned services.
- Stabilisation of recruitment and retention issues in general practice.
- A new framework of recruitment for allied care staff.
- Time-relevant components of the GP Five Year Forward View in place.

5.3 Timescales

This component of the programme will be delivered by the end of Q4 of 2017/18 in the following stages:

- **Q1**: Response to evaluation of proactive care pilot and plan to develop cluster working, implementation of practice variation work stream, commence development of frameworks for recruitment and retention, review of existing locally commissioned services (LCS).
- **Q2**: Map existing LCS into the Caring Together programme, development of commissioning intentions for LCS, implementation of

cluster plans, further development of recruitment framework and other continuing work.

- **Q3**: Commissioning of LCS underway, practice variation work continuing, embedding new ways of cluster working.
- **Q4**: Completion of all work streams: clusters embedded and fully working, alignment with social care and other service providers, practice variation work complete, final LCS commissioned, recruitment frameworks in place.

6. Deliverable 2: Federating General Practice

The journey towards federating general practice within Brighton & Hove has been the subject of much opinion and debate over the previous years. While there has been a programme of development for federated working and the cluster working as part of Proactive Care has been an undoubtedly positive development in this area, the decision to federate following a vote in the summer of 2016 was far from conclusive and limited progress has been made in this area since that time. Following the passage of time to this point, it is best to view the previous decision as an advisory process and a programme of engagement has taken place with partners, contracted GPs, practice managers and other practice staff during Q4 of 2016/17. Three GP engagement events have taken place to review various models and to discuss options.

The CCG recognises that it must work closely with the Local Medical Council (LMC) if it is to move this agenda forward and, to that end, an understanding and an agreement has been reached for all parties to work together in a spirit of cooperation and openness to seek a solution to the question of how to federate general practice in Brighton.

It remains the strategic objective of the CCG to reach a position where there is a federated environment for general practice in Brighton & Hove but it is acknowledged on all sides that this will require a full programme of consultation, engagement and support to reach a mutually agreeable position. To this end, the outputs and the criteria for success are necessarily described at a reasonably high level in this Programme Description.

Consequently, the CCG remains focused on supporting general practice in this objective so that the new ways of working developed through Deliverable 1, above, can support general practice to be sustainable into the future and to present itself in as strong a position as possible to face the challenges in the years ahead.

6.1 Purpose:

The following describes the purpose of this deliverable:

- To support primary care in the City to develop a strong organisational composition that enables it to meet the need-demand and financial challenges of the future.
- To work with the LMC to develop a federated primary care structure to co-ordinate the City-wide discharge of primary care service provision and to provide a robust structure to deliver the new model of care.

6.2 Criteria for Success:

The following outputs are expected from this deliverable and will be used as the criteria by which successful delivery of the work will be measured:

- Successful engagement processes supported by the LMC, at the end of which, general practice recognises that the proposed organisational composition delivers a way of working that is sustainable and supportive.
- A formally federated structure that is capable of acting as a representative legal entity, capable of contracting for the delivery of primary care services in the City.

6.3 Timescales

This component of the programme will be delivered by the end of Q4 of 2017/18 in the following stages:

- **Q1**: Formal agreement to proceed to a federated structure, legal processes, agreement of prime funding by the CCG for project development work, constitution of a Board, executive roles, officers and administrative support.
- **Q2**: Development of structures and objectives for delivery.
- **Q3**: Initial moves towards a new federated way of working, continuing development of opportunities and initial activity commissioned by and/or through the federated entity.
- **Q4**: Final sign-off of the development project, implementation of legal constructs and go-live of initial contracted functions.

7. Deliverable 3: New Model of Care

The delivery framework described in Deliverables 1 and 2, above, provides the organisation model through which the clinical programmes and the new model of care will be delivered. The Clinical Strategy, which is comprised of the six clinical programmes, comprises the new model of care and this will be delivered through a contracting mechanism that is agreed by the CCG.

During discussions to agree the local approach to the STP, the CCG, along with the other CCGs in the CSESA area, has previously identified a Multi-Speciality Community Provider as an appropriate model for delivering the model of care in this area. Nevertheless, due to the organisational changes that are taking place at an STP level and the clear view from general practice and the LMC with Brighton & Hove that it is not in a position to consider which contracting model would be most appropriate for the City, all options are being kept under review at this stage.

While the clinical programmes will continue to deliver their outcomes, and development of a federated vehicle for general practice will proceed through Deliverable 2, consideration of a contracting mechanism for delivering the overall model of care is unlikely to commence until Q1 of 2018/19 at the earliest.

The CCG and the LMC have both been clear that the delivery of any model must be the right one for Brighton & Hove, irrespective of external influences.

7.1 Purpose:

The following describes the purpose of this deliverable:

- To develop and deliver a model of care that provides a strong and resilient framework for the clinical programmes within the Clinical Strategy.
- To work towards developing a delivery model that supports integration and alignment of non-acute services and functions within a single set of pathways.
- To work towards aligning service delivery in Brighton & Hove with the STP-agreed approach to realigning patients flows from an acute to a non-acute environment through new models of care.
- To build on the successful mechanisms within the Better Care Fund programme by continuing to develop pooled budgets with the local authority to deliver health and social care in a single environment.

7.2 Criteria for Success:

The following outputs are expected from this deliverable and will be used as the criteria by which successful delivery of the work will be measured:

- A measurable shift in activity from acute to non-acute settings, delivered through a new model of care.
- Genuinely pooled budgets being used to commission integrated services.
- A measurable shift in speciality and out-patient services being offered more consistently within the community setting.

7.3 Timescales

This component of the programme will aim for delivery by the end of Q4 of 2018/19 in the following stages, although this is subject to change in the light of potential structural and broader organisational changes:

(a) 2017/18

- **Q4**: Project scoping and development informed by the outputs of Deliverables 1 and 2, above, and the outcomes from STP development.

(b) 2018/19

- **Q1**: Continuing project scoping with support from all interested parties, including the LMC to continue through Q2 and Q3.
- **Q4**: Development of formal proposals for new models of working to deliver the models of care in the clinical programmes, as they develop beyond the period of the Operating Plan 2017-19.

8. Clinical Programmes: Governance and the CCG's Clinical Strategy

Each of the six clinical strategies will have its own Clinical Programme Board, which is responsible for delivering the outputs and the project work within the strategy. The Board will be chaired by the nominated CCG Clinical Lead, supported by the appropriate Heads of Commissioning from both the CCG and, where appropriate, the local authority. Boards will comprise project leads, clinical, finance, quality, audit and other appropriate colleagues. All the Boards report by exception through the Programme Executive Group to the Transformation Partnership Board according to standard MSP/Prince2 programme methodology and supported by a full PMO process.

The clinical programmes together comprise the CCG's Clinical Strategy. Once the programmes have all been signed off by their Clinical Leads and their Programme Delivery Boards, the combined Clinical Strategy will be presented to the CCG's Governing Body for formal sign off. This will take place at the end of Q1 of 2017/18 once all the Boards have been formally constituted and have met.

9. Clinical Programme 1: Preventative and Community Care

This clinical programme represents the implementation of the preventative and community care components of the CCG's Operating Plan and includes the greatest areas of working with the local authority, Public Health and with community and acute providers. This is a significant programme both in terms of delivery commitment and of priority and the development of this programme has identified that there are two significant projects to be developed that will each deliver a number of outputs.

Project A: Self-Management and Social Prescribing

This project will be formally constituted and commence activity in Q1 of 2017/18. Consequently, it has been identified as a PRIORITY project within the programme.

Led by Public Health and using localy-evidenced approaches to embedding self-care, care navigation, telehealth and social prescribing, the project will look to develop and pilot new ways of working, particularly with local authority support, throughout the programme. Working across many of the other implementation projects as well, this work will embed preventative-focused activity throughout the Caring Together programme, meeting the requirement of all clinical programmes to address prevention as a principal component of delivery.

Project B: Effective Community Pathways

This project is the most significant and intensive of any activity within the overall programme. It seeks to redesign the community pathways activity around admission avoidance, supported, timely discharge, intermediate care services (step-up and step-down), reablement, new ways of working, single access arrangements, RACOP, Continuing Health Care assessments, community equipment processes and integration of functions within primary care localities.

This project has been identified as a PRIORITY project within the programme and among its principal activities are:

- Implementing an efficient programme of community bed-based services to ensure clinically appropriate pathways to avoid unnecessary admissions and to improve discharge processes, particularly 'discharge to assess'.

- Realigning clinical responsibilities to reduce handovers to specialist roles with alignment to STP workforce outputs.

- Implementing the principles of Right Care by commissioning community-based consultant-led care in frail and elderly pathways and a Children's Community Nursing Team.
- Improving communication and hand-overs by expanding and aligning pan-community single point of access processes.
- Ensuring financial sustainability by developing a new, integrated Community Equipment Service with local authority partners.

Additionally, local authority modernisation imperatives included within this project include:

- Further roll-out of Telecare system supported by 24hour CareLink service providing support for admission avoidance and timely discharge.
- Developing an integrated accommodation strategy.
- Integrating OT services within HASC, FCL and Housing with a view to incorporating the new service within the three districts (see also Deliverable 1).
- Reviewing the Rough Sleepers Programme to overhaul how temporary accommodation is sourced and allocated.

9.1 Purpose:

The following describes the purpose of this deliverable:

- To create genuinely aligned and, where practicable, integrated community health and social care functions that support admission avoidance and timely discharges from acute care, thereby reducing acute activity and increasing positive patient and service user experience metrics.
- To redesign pathways and processes around frailty, including the implementation of a community frailty consultant service.
- To commission and implement a new structure of community bed-based services to support step-up and step-down services and prevent unnecessary hospital admissions.
- To implement new ways of working with teams, clusters, localities and City-wide to reduce hand-overs and to increase the positive patient and service user experience, including implementing efficient single point of access functionality.
- To implement new ways of working around community equipment.
- To implement new ways of working within Continuing Health Care.
- To integrate local authority and potentially all Occupational Therapy services.
- To review accommodation strategies, particularly in respect of rough sleepers.

9.2 Criteria for Success:

The following outputs are expected from this deliverable and will be used as the criteria by which successful delivery of the work will be measured:

- Community services operating efficiently in aligned team structures within clusters and/or localities, reducing hand-offs and improving the patient and service user pathway and experience.
- Measurable reduction in avoidable admissions to acute care, including A&E referrals and conveyances by SECAmb as a result of the implementation of a community frailty service and improved pathways and use of assessment step-up beds.
- Measurable reduction in delayed discharges due to efficient use of step-down beds for discharge to assess activity.
- Improved efficiency through the system and reduced hand-offs through integrated single point of access functionality.
- Measurable improvement in homelessness activity through reviewed accommodation strategy, particularly in respect of rough sleepers.
- Measurable improvement in customer experience and financial impact through improved management of the community equipment service.

9.3 Timescales

This component of the programme will be delivered by the end of Q4 of 2018/19 in the following stages:

2017/18

- **Q1**: Review outputs of Proactive Care pilot evaluation, define commissioning objectives around community short-term services, frailty network, single point of access and community equipment.
- **Q2**: Develop commissioning intentions, service redesign around working practices and hand-offs.
- **Q3**: Procurements for community short-term services and frailty, continuing service redesign elsewhere, develop commissioning intentions around single point of access.
- **Q4**: Continuing procurement and begin implementation of community services, begin procurement of single point of access, continuing service redesign. Go live for initial community bed-based services.

2018/19

- **Q1**: Continuing procurement and implementation of community services, implementation of service redesign.
- **Q2**: Implementation of community frailty network, implementation of single point of access.

- **Q3**: Go-live of single point of access, further community bed-based services online.
- **Q4**: Final implementation of project outputs, go live of final components for Q1 of 2018/19.

10. Clinical Programme 2: Planned Care

The NHS Constitutional Referral to Treatment (RTT) standards have not been met locally for the past two years. During this period the available capacity at our local acute trust has not been sufficient to meet demand and, as a result, a significant waiting list has developed. In addition, data quality issues have hampered our ability to accurately quantify the issues.

The Operating Plan 2017/19 is clear that the development of the system-wide recovery plan in 2016/17 marked a turning point in our approach to planned care. The plan is based on significantly improved data and focused on plurality of provision, patient choice and managing demand.

Using the RightCare Methodology, the CCG has set out in the Operating Plan how it will address the failure to meet its constitutional standards for referral to treatment times and the Caring Together Programme refines these ambitions further into a series of project-based deliverables.

10.1 Purpose:

The following describes the purpose of this deliverable:

- To deliver pathway redesign and to support the development of a community Cardiology Service, alongside reducing unnecessary interventions through the Community Anti-Coagulation Service.
- To implement pathway redesign around neurology services.
- To reduce activity to address RTT and deliver better quality of care around digestive diseases.
- To implement the Brighton & Hove Cancer Strategy and to meet the requirements of NG-12.
- To implement a programme of ENT and Ophthalmology activity shift from acute to community settings.
- To increase activity within the Community Endoscopy service and promote activity shift.
- To align clinical thresholds for service referral in the MSk Service.
- To implement a stable primary care urology service.
- To implement and enhance referral management services through developing processes and redesigning pathways through Optom.

10.2 Criteria for Success:

The following outputs are expected from this deliverable and will be used as the criteria by which successful delivery of the work will be measured:

- Measurable reduction in mortality as a result of cardiovascular disease, which is currently the most significant cause of mortality in the city.
- To reduce RTT times and meet national targets by implementing straight-to-test pathways for neurology and digestive diseases.

- To achieve targets for RTT and NG-12 measured as one-year survival rates rising from 69% to 75%.
- Measurable activity shift from acute to community settings for ENT, Ophthalmology and Endoscopy services.
- Measured alignment of clinical thresholds in MSk.
- Measurable reduction in avoidable referrals due to pathway redesign and referral management processes.

10.3 Timescales

This component of the programme will be delivered by the end of Q4 of 2018/19 in the following stages:

2017/18

- **Q1**: Evaluation and options appraisal on anti-coagulation, review of workforce training in neurology, review of digestive disease referrals, active review of cancer referral rates, peer review of ENT and ophthalmology, procurement of additional community endoscopy, develop urology business case.
- **Q2**: Analysis of existing CVD data, review referral management processes, implementation of community endoscopy capacity, options appraisal on digestive diseases, pilot intermediate tier headache service.
- **Q3**: Options appraisal on CVD, peer review on neurology and digestive diseases, alignment with other CCG ENT and ophthalmology services, implement urology contract, align pathways in referral management.
- **Q4**: Implement CVD service, clinical audit of neurology, procurement for other neurological diseases, cystoscopy pathway redesign.

2018/19

- **Q1**: Review MSK contracts, negotiations and discussions with CVD provider, implement neurology services, procure ENT and ophthalmology services, referral management business case.
- **Q2**: Review options for continuing neurology service delivery, implement ENT and ophthalmology, procurement options for referral management.
- **Q3**: CVD and MSK procurement, potential procurement of neurology and additional community endoscopy.
- **Q4**: Implementation of CVD, neurology (potentially), digestive diseases, endoscopy and referral management.

11. Clinical Programme 3: Access to Primary Care and Urgent Care

If the local healthcare economy is serious about activity shift from acute to primary care, it has to ensure that there are sufficient, deliverable primary care alternatives available to prevent people choosing 24-hour A&E access. The principal objective of this clinical programme, therefore, is to deliver seamless, 24 hour, seven day access to primary care through extended hours' general practice, urgent care centres in town and at the front door of the hospital and out-of-hours provision.

The purpose of this objective is to review, overhaul and recommission a primary care system that uses the resources of various providers and facilities to deliver an integrated, 24/7 environment to respond to the objectives of the Caring Together agenda.

This is about integrating the various components of primary care delivery in an aligned delivery model, including reviewing the non-practice delivery mechanisms, e.g. walk-in centre and primary care presence at A&E to support improvement in the four-hour waiting time target at BSUH.

This clinical programme confirms the commitment of the local system to meeting the challenges set by the General Practice Five Year Forward View; in particular the delivery to our population of improved access, the funding and transformation of new models of care and the development of a sustainable and skilled workforce to deliver these ambitions.

The CCG will additionally be increasing investment into General Practice in 2017/18 and 2018/19 in line with the proposals set out in the General Practice Five Year Forward View (FYFV). Using this additional funding, it will support practices in the timing of appointments and commissioning additional consultation capacity. In addition, there will be an increase in advertisements regarding services to patients including publicity of practice, pharmacy and dental service opening hours so that it is clear to patients when they are able to access these services. Practice receptionists will also be trained to signpost patients to services and new consultation types will be delivered, such as online consultations.

11.1 Purpose:

The following describes the purpose of this deliverable:

- To commission extended access to general practice through additional funding, to include 'Practice Assist'.
- To commission primary care facilities at the 'front door of the acute hospital as a component of 24/7 access to primary care and to support the hospital to achieve its improvement plan to meet national standards.
- To commission resilient GP out-of-hours services, including using a clinical navigation hub model.
- To review and developed the commissioned 'Roving GP' service.
- To play an active and influential part in the Sussex-wide NHS111 reprocurement.

11.2 Criteria for Success:

The following outputs are expected from this deliverable and will be used as the criteria by which successful delivery of the work will be measured:

- Meaningful and measurable additional access to GP services resulting in a significant, positive impact on the sustainability of general practice in the City.
- Delivery of a resilient primary care presence at the front door of the acute hospital resulting in activity shift away from primary care and supporting the Trust's Quality Improvement Plan to reduce RTT times.
- Delivery of a local and sub-regional response to GP out-of-hours facilities through effective re-procurement of NHS 111 and the development of a local clinical decision hub resulting in measurable activity shift from acute activity, notably A&E attendance and waiting times.
- Delivery of an effective 'Roving GP' service supporting general practice to operate more efficiently and to support the development of cluster and locality working.

11.3 Timescales

This component of the programme will be delivered by the end of Q4 of 2018/19 in the following stages:

2017/18

- **Q1**: Engagement and definition of commissioning intentions in extended access services and primary care presence at the 'front door' of the acute trust, develop commissioning intentions for NHS 111 and Clinical Hub.
- **Q2**: Business case development, project work-up and decision making for activities from Q1.
- **Q3**: Procurement activity, as appropriate, running through into Q4, as necessary.
- **Q4**: Continuing procurement and move to implementation, as appropriate.

2018/19

- **Q1**: Implementation projects running through Q1 and Q2 with broader alignment of primary care and urgent care access through the clinical programme..
- **Q2**: Continuing implementation and go-live of first services.
- **Q3**: Go live, monitoring, evaluation.
- **Q4**: Go live, monitoring, evaluation..

12. Clinical Programme 4: Mental Health, Learning Disabilities, Children & Families

Commissioning an integrated mental health environment where access to high quality mental health services recognises the complex interdependencies of mental health care across health, social care and voluntary sector services. There are a significant number of national 'Must Dos' relating to mental health, including:

- Increased access to additional psychological therapies and increased high-quality mental health services for children and young people.
- Delivery of mental health access and quality standards e.g. through 7 day access to the commissioned Crisis Resolution Home Treatment (CRHT) Service.
- Maintenance of the dementia diagnosis rate.
- Elimination of Out of Area Placements for non-specialist acute care by 2020/21.

In addition to primary adult mental health, this clinical programme will oversee a significant programme of development in respect of children's and young people's mental health services, perinatal care, reduction in suicide rates and community and voluntary sector procurements.

In respect of learning disability, the programme focuses on the national 'Transforming Care' agenda, particularly in respect of autism diagnosis and treatment pathways.

The programme additionally focuses on implementing the maternity five year forward view 'Better Births', the delivery of the Homeless GP Practice alongside integrated care for the homeless (linked to Clinical Programme 1 in respect of rough sleepers) and is scheduled to establish a pilot consultant paediatric clinic and a Community Nursing Team.

12.1 Purpose:

The following describes the purpose of this deliverable:

- To deliver increased access to IAPT services.
- To deliver increased and enhanced CAMHS services.
- To work closer with Housing and Homelessness Services.
- To deliver a measurable reduction in suicide rates.
- To deliver excellent performance against dementia diagnosis targets.
- To eliminate out-of-area placements for non-specialist acute care (QIPP) and to reduce the number of specialist out-of-area placements.
- To agree new pathways for autism diagnosis and treatment.
- To implement the detail of the Maternity Five Year Forward View.

12.2 Criteria for Success:

The following outputs are expected from this deliverable and will be used as the criteria by which successful delivery of the work will be measured:

- Agreed measures delivered for increasing IAPT referrals.
- Increased and measurable referrals and outputs from CAMHS Service.
- Elimination of out of area non-specialist acute placements.
- Agreed reduction of the number of specialist out-of-area placements.
- Implementation of new autism pathways.
- Implementation of the detail of the Maternity Five Year Forward View.
- All practices are signed up to SMI LCS.

12.3 Timescales

This component of the programme will be delivered by the end of Q4 of 2017/18 in the following stages:

2017/18

- **Q1**: Mobilise community welfare service, schools wellbeing service, specify community health services and deliver IAPT targets, integration with Homeless service.
- **Q2**: Agree and implement model for perinatal care, mobilise new IAPT contract, specification for primary mental health services, business case for integrated children's integrated hub.
- **Q3**: Continuing review of out-of-area placements, implementation of Community Nursing Team.
- **Q4**: Evaluation of community hubs – maternity, community and voluntary sector contracts live.

13. Clinical Programme 5: Medicines Optimisation

Medicines optimisation is already working to a clinical delivery programme and this will be expanded and developed as a consequence of being included within the Caring Together Programme.

There are three principal outputs within this clinical programme:

- Establishing unified community medicines optimisation within General Practice.
- Education, Development and Support in Medicines Optimisation.
- Development and implementation of a paediatric formulary.

The purpose of this programme is to optimise the use of medicines across the Brighton and Hove health economy to ensure that the right patient receives the right choice of medicine at the right time to improve patient outcomes.

13.1 Purpose:

The following describes the purpose of this deliverable:

- To align and embed community pharmacy as an integrated component of the primary care offering by aiming to transfer the various components within a single, contracted vehicle.
- To deliver a meaningful education, support and development programme for primary care practitioners to support better medicines outcomes.
- To expand the number of non-medical prescribers within primary care.
- To deliver a paediatric formulary.
- To support patients to take medicines correctly and to avoid taking unnecessary medicines.
- To reduce medicine wastage.
- To improve medicine safety.

13.2 Criteria for Success:

The following outputs are expected from this deliverable and will be used as the criteria by which successful delivery of the work will be measured:

- Community pharmacy functions are embedded within primary care under a coherent employment strategy to support the programme's purpose.
- A measurable reduction in unnecessary prescribing.
- A measurable reduction in medicine wastage.
- A measurable improvement in medicine safety.
- A children's formulary has been rolled out.

13.3 Timescales

This component of the programme will be delivered by the end of Q4 of 2018/19 in the following stages:

2017/18

- **Q1**: Defining commissioning objectives after the Proactive Care pilot evaluation, focused review of care homes and risk stratification of high-risk users, promoting non-medical prescribing within general practice, enhanced skills training.
- **Q2**: Continuing training, promotion and review, repeat prescription audits, incentivised support.
- **Q3**: As Q2 also implementation of electronic prescribing across the City and begin development of paediatric formulary and recommissioning of Better Care pharmacists.
- **Q4**: As Q2-Q4 plus Better Care Pharmacists working in clusters.

2018/19

- **Q1**: Continuing engagement in 'Help My NHS', further campaigning, delivery of paediatric formulary.
- **Q2**: Negotiations for transfer of community pharmacists to general practice.
- **Q3**: Potential transfer of community pharmacists, continuing education and engagement.
- **Q4**: Community pharmacists working directly in general practice.

14. Clinical Programme 6: New Models of Acute Care

The clinical programme around the new models of acute care will focus on the relationship with Brighton & Sussex University Hospital NHS Trust (BSUH) and will be accountable for overseeing the consequences of any partnership arrangements with Western Sussex Hospitals.

The clinical programme will also be responsible for maintaining focus on the Quality Improvement Plan at BSUH, including organisational response to the RTT targets, the Brighton site redevelopment and interfacing with the community programmes in respect of timely supported discharge.

The programme is responsible for commissioning, contracting and performance issues relating to the South East Coastal Ambulance Trust (SECAmb).

Significantly, the clinical programme is also responsible for managing the relationship between Brighton & Hove's health and care economy and the development of the STP in respect of acute provision.

14.1 Purpose:

The following describes the purpose of this deliverable:

- To oversee the relationship with the acute trusts, as they affect the Brighton & Hove health and care economy.
- To support BSUH in implementing its Quality Improvement Plan.
- To support BSUH in its site redevelopment.
- To support other workstreams in respect of hospital processes.
- To manage issues as they relate to SECAmb.

14.2 Criteria for Success:

The following outputs are expected from this deliverable and will be used as the criteria by which successful delivery of the work will be measured:

- Improved financial prospect and outcomes for patients as a result of partnership arrangements.
- Measured, improved performance towards achieving Referral to Treatment national targets and standards.
- BSUH meeting is project plan targets in respect of site redevelopment.
- Relationship and issues with SECAmb at satisfactory levels.

14.3 Timescales

This component of the programme will continue to be throughout the two years of the programme.

15. Deliverable 10: Information Management and Technology (IM&T)

Underpinning the whole delivery programme is the IM&T Deliverable. As part of the CCG's commitment to the STP, a 'Local Digital Roadmap' has already been completed and the deliverables and timescales for IM&T delivery across the City are contained within that document.

The Caring Together Programme will provide the delivery framework for the LDR, as this underpins all the work to support the programme. A separate delivery team working across the CCG and the local authority, as well as with relevant officers from provider organisations will be established to deliver both the IM&T components and the performance and data requirements to support development and implementation of the programme.

16. Enabling Workstreams

The enabling workstreams that support the programme will be continuously delivered alongside the rest of the programme and will fit in with both the timescales for the clinical delivery programmes but also national requirements, including funding opportunities and reporting obligations. Each clinical programme and other deliverable will align its enabling workstream interfaces with this overall programme and these will be embedded in the specific project documentation as it relates to the specific deliverable within the clinical programmes.

The enabling workstreams will also be supported by the CCG's formal PMO function.

17. Enabling Workstream A: Engagement and Co-Production

With any programme of this scale, engagement with relevant stakeholders and partners is essential. The programme direction has taken the view that it is important for stakeholders to play a central part in developing and co-producing the overall engagement plan and initial meetings to start this process are scheduled for the end of March 2017, although informal conversations have been taking place since the previous significant engagement events at the outset of the programme in Q3 of 2016/17.

A detailed stakeholder engagement plan will be developed as part of the formal programme documentation. It will be owned, maintained and reviewed by the Transformation Partnership Board to ensure that it is managed and delivered at the highest level of the programme.

18. Enabling Workstream B: Estates Management

Estates management will feature as a key component of a number of the deliverables and it is an essential part of the overall programme. Currently, the clinical estate is comprised of the estate portfolios held by BSUH, SCFT, SPFT, GP practices and the Local Authority. Generally services are provided within these estates although some services are commissioned to operate in other providers' estates in order to facilitate increased integration (for example Better Care workstreams).

Over the forthcoming years, integrated working will increase with improved space use and co-location of services to deliver joint health and social care outcomes in clinical estates. As a result, we will be building on the existing joint strategic working across health and social care and all General Practice premises will be of a high quality standard, enabled by the Primary Care Transformation Fund. In addition, hub and spoke models will be used more for improved service delivery, and out of hours working will become more frequent to better utilise assets and meet the needs of the population.

During the course of the programme, estates will need to be rationalised, particularly where it is poor value for money or under-used and savings may be required to invest in other estate elsewhere. Flexible deployment and cultural change aligned to clusters will enable more intensive use of a higher quality yet reduced footprint. An audit will be undertaken to review environmental performance and impact on staff wellbeing.

19. Enabling Workstream C: Financial Accountability and Transparency

The programme will be supported by a robust financial framework:

- All programmes of work will be financially controlled through the budget setting and monitoring process to ensure robust financial budget management.
- The QIPP Programme is now aligned to the same programme management methodology (PMO) as Caring Together, so the financial benefits of QIPP Schemes are embedded within the Programme and the CCG's overall financial strategy.
- There will be more transparency over provider financial pressures.
- Caring Together ensures financial transparency for Brighton & Hove within the STP/CSESA programme.
- Management of the section 75 Agreements under the Better Care Programme will transfer to the Financial Accountability and Transparency Enabler of the Programme and the BCF Board will be wound up.

20. Enabling Workstream D: Workforce Development

Analysis and response to workforce development issues is an essential component of delivering successfully a programme of this scale. Many of these issues are tackled most appropriately at a higher level due to the multiple interdependencies of such a complex workforce landscape. Many such challenges will, therefore, be addressed at an STP or a sub-regional level to ensure that quality solutions are implemented. Among the workforce development issues that this enabling work stream will tackle are the following:

- The need to work with practices to examine the skill mix in practices and across multi-organisational community teams, and to develop career pathways to offer newly qualified staff real opportunities to achieve varied and structured development in the community from point of qualification.
- Encouraging practice nurses to upskill and develop so they can take on extended roles, including undertaking MSc specialist practice pathway in general practice nursing.
- Promoting non-medical prescribing for clinical staff, principally within pharmacy.
- Supporting Healthcare Assistants (HCAs) to upskill through a competency framework and apprenticeships.

- Working with larger NHS providers to support primary care and nursing home practitioners to access multi-organisational consistent high quality training and development through the use of skills labs across Sussex.
- Working closely with HEE-KSS and the STP footprint to develop Community Education Provider Networks (CEPN).
- Brighton and Sussex Medical School is designing the development and delivery of a Physician's Assistant (PA) curriculum and it is expected that placements will be required from 2017.
- The CCG along with STP partners will determine strategies for reducing locum costs and invest in Clinical Champions to work with the Royal College of General Practitioners and HEE-KSS.
- Supporting the development of pharmacy technicians.

21. Governance

To ensure that decisions are taken by the right people, in the right places and at the right time, and are overseen by an accountable, decision-making structure, the programme will be run in accordance with a full and formal governance structure.

Good governance ensures that the outputs of the local programme in Brighton & Hove align with the Sustainability and Transformation Plan (STP) for Sussex and East Surrey and the Central Sussex and East Surrey Alliance (CSESA) sub-STP footprint. It also means that the operational functions that arise from delivery of the programme have a good, long-term structure to house them after they have been delivered.

The programme will broadly be controlled using a Managing Successful Programmes (MSP) and Prince2 project management methodologies, adapted for local and scalable use and supported by a full PMO process. The principal components of the governance arrangement will be as follows:

- Top-level sponsorship via the Health & Wellbeing Board and the CCG's Governing Body.
- Overall programme direction through the Caring Together Transformation Board, comprising senior decision-makers from the relevant organisations within the City.
- A Programme Executive Group to coordinate direction of the programme and to manage risks, issues and interdependencies from each of the clinical programmes.
- Individual Clinical Programme Boards for each clinical programme, chaired by a clinical lead and supported by relevant executives and officers from all appropriate organisations to ensure continuing focus on delivery.
- Accountability to the City Council's ASC Modernisation Board, as appropriate according to individual outputs.
- Project Teams to ensure focused delivery of the individual outputs running through formal Prince2 methodology alongside a dedicated Programme Management Office (PMO) process supporting the projects and deliverables through every step.
- A dedicated Programme Director overseeing the whole programme end-to-end and responsible to the Transformation Programme Board for delivery.

22. Programme Delivery Plan

The high-level Programme Delivery Plans for each of the clinical programmes, which have been distilled from the individual work package timescales, as set out on the relevant headings, above, are attached to this programme definition as Appendix 'A'.

(Note: currently only the plan for Clinical Programme 1 is attached, as the others are in the process of sign-off by the relevant teams. By the time of the Governing Body meeting on 28 March 2017, all plans will have been completed.)

23. Programme Prioritisation

This is a large and complex programme that comprises all the transformational and commissioning activity of the CCG and a significant component of the externally-facing modernisation programme of the City Council. As a consequence, it has been necessary during development to identify the areas that can be substantially delivered during 2017/18. The following is a summary of the areas that should be considered for a start in Q1 of 2017/18 and that have a reasonable chance of delivery during the year:

(a) Cluster working. The programme to establish cluster working as an evolution of the Proactive Care pilot to ensure that locality-based cooperation continues to develop.

(b) Development of Federated Primary Care options in partnership with the LMC.

(c) Self-Management and Social Prescribing: as an underpinning project to support admission avoidance and to keep people healthy and well. Led by Public Health.

(d) Community Services Development: the broadest ranging project that will last for two years but needs to be initiated as quickly as possible due to the complex interdependencies, particularly community service providers and the local authority and the significant benefits to be gained.

(e) Cardiovascular Disease and Anti-Coagulation: due to its status as the most significant cause of mortality in the City and the performance failure at present in delivering preventative services.

(f) Non-Practice Access to Primary Care: implementing solutions around extended access, Walk-In Centre, Primary Care Presence at A&E, GP Out-of-Hours and Roving GP Service. These together comprise the significant primary care response to people accessing services through the hospital, although not all will be deliverable exclusively in 2018/19.

(g) Resolution of Mental Health out-of-area specialist and non-acute placements, due to significant overspend in these areas.

(h) Alignment of all Community Pharmacy: to implement a programme of alignment of the various community pharmacy contracts and potential transfer to a provider organisation, e.g. a GP Federation.

24. Communications Plan

A high-level communications and stakeholder engagement plan has been developed and will be available shortly by contacting Tom Gurney, Head of CCG Communications, on thomas.gurney@nhs.net.

25. Risks

The programme will manage risk through the Clinical Programme Boards and the Executive Group using a standard Prince2 risk management methodology with escalation to the Partnership Board. Initial risks and mitigation include:

- Historical scepticism about restructuring from general practice; mitigated by engagement, explanation and openness.
- Poor outcomes from engagement with partners, providers and the public; mitigated by linking engagement activity to the outputs of the individual deliverables and how these will change the world.
- Inflexibility in workforce due to limited opportunity for skills development; mitigated by working on a broader STP footprint.
- Maintaining focus on primary care transformation when there is a distracting process of implementing co-commissioning; mitigated by clarity over the implementation plan for co-commissioning.

26. Benefits and Opportunities

The product of the programme will be the delivery of benefits, both financial and non-financial and will support the delivery of efficient working throughout the local health and care economy. Additionally, the programme may deliver a number of consequent opportunities:

- The initiation of a formal programme of system-wide restructuring will enable the CCG and the Council to work together for genuine health and social care change with meaningfully pooled budgets.
- The new leadership at BSUH provides an opportunity to develop new ways of working unclouded by historical issues.
- Meaningful engagement with general practice provides the opportunity to support, enhance and change primary care.
- Community and voluntary sector providers will be empowered to find new and creative ways of working within the MCP and new model of care, improving services for patients, carers and families.
- The development of federated working will deliver clarity over the organisational role and function of 'HERE' within the Brighton & Hove provider landscape.
- The overall programme delivery structure enables the CCG to move into a delivery environment with managed outcomes and outputs.
- The programme will highlight certain operational issues that will need to be reviewed as the clinical programmes are implemented.
- The whole delivery structure of general practice against the background of co-commissioning, creation of a federation structure, the relationship with HERE.
- The programme will provide a structure within which BSUH performance can be meaningfully assessed, measured and improved against the whole health and care economy in Brighton & Hove for the first time as a single system.
- The Community Short Term Services re-design will be a test of how well the CCG and the Council can create joint solutions that provide more care at

home, support delayed transfers of care in the acute, reduce length of stay and offer a step up in the community to avoid hospital admission.

27. Challenges

Some wider system challenges have been identified as follows:

- Significant financial challenges to the overall system from real-terms reducing budgets against growing demand and increasing complexity
- Limited transformational capacity to deliver change in both commissioner and provider organisations.
- The impact of local and national political imperatives.
- To ensure that all regional decisions are compatible with Brighton & Hove health and social care economy
- Maintaining positive and progressive relationships with partners in commissioning, provider and voluntary sectors throughout the challenges in delivering the programme.
- Ensuring continuing focus on commissioning activity that crosses the clinical programmes, e.g. maternity, children's and families.

28. Quality

Quality is embedded throughout the programme and sits at the heart of transformation. Where efficiency is introduced into any process, it should bring with it an increase in quality outputs.

- Quality across delivery will be aligned by using the MCP as a vehicle for ensuring consistent quality expectations across providers and processes and implementing a unified programme for improvement.
- Workforce quality standards will be raised by consistent application of processes and delivery expectations, including a reduction in hand-offs between organisations.
- Use of existing quality standards information to support more coordinated and effective commissioning for quality outcomes.
- Safeguarding and other serious incidents (SIs) will be more efficiently uncovered through more efficient process working across specialities and a greater understanding of triggers in other disciplines, etc.

29. Further Information

For further information, in the first instance please contact the CCG's Head of Communications, Tom Gurney (thomas.gurney@nhs.net).

Prevention & Community Care Clinical Programme Plan

(as an illustrative example; all plans will be completed by the date of the Governing Body meeting on 28 March 2017)