
## Who are we?

The Health and Wellbeing Board is the forum where representatives of the Council, NHS and Third Sector hold discussions and make decisions on the health and wellbeing of the people of Brighton & Hove. Meetings are open to the public and everyone is welcome.

## Where and when is the Board meeting?

This next meeting will be held in the Council Chamber, Hove Town Hall on Tuesday 12 September 2017 starting at 4.00pm. It will last about two and a half hours.
There is limited public seating available for those who wish to observe the meeting. Board meetings are also available to view on the council's website.

## What is being discussed?

- Integration of Health and Social Care
- Better Care Plan
- Brighton & Hove Cancer Strategy
- Breastfeeding Update Report

# Health & Wellbeing Board

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| **Geoff Raw**<br>BHCC<br>Chief Executive | **Daniel Yates**<br>**Councillor**<br>Chair | **Elizabeth Culbert**<br>Legal Adviser | Secretary to the Board |

**Adam Doyle**
**CCG**
**(Voting member)**

**Nick Taylor**
**Councillor**
**(Voting member)**

**Dawn Barnett**
**Councillor**
**(Voting member)**

**Peter Wilkinson**
(Non-voting Statutory member)

**Lola BanJoko**
**CCG**
**(Voting member)**

**Dr Manas Sikdar**
**CCG**
**(Voting member)**

**Graham Bartlett**
(Safeguarding Boards Adults & Children
(Non-voting co-optee**)**

**Pinaki Ghoshal**
(Non-voting Statutory member)

**Caroline Penn**
**Councillor**
(Non-voting invitee)

**Karen Barford**
**Councillor**
**(Voting member)**

**Malcolm Dunnett**
**CCG – Lay member**
**(Voting member)**

**Dick Page**
**Councillor**
**(Voting member)**

**Rob Persey**
(Non-voting Statutory member)

**Dr David Supple**
**CCG**
**(Voting member)**

**David Liley**
Healthwatch
(Non-voting Statutory member**)**

**Pennie Ford**
NHS England
(Non-voting co-optee**)**

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| **Public Speaker** | **Public Speaker** |

**Public Seating**
For those with public items on the agenda

**Press table**

**Health & Wellbeing Board**
**MeetingDate**
**4.00pm**
**Hove Town Hall, Council ChamberCouncil Chamber, Hove Town Hall, Norton Road, Hove, BN3 4AH**

Who is invited:

**Voting Members:** Cllrs Daniel Yates (Chair), Karen Barford, Dawn Barnett, Dick Page and Nick Taylor; Dr David Supple, Adam Doyle, LolaBanjoko, Malcolm Dunnett, and Dr Manas Sikdar (Brighton & Hove Clinical Commissioning Group).

**Non-Voting Members:** Geoff Raw, Chief Executive; Rob Persey, Statutory Director of Adult Services; Pinaki Ghoshal, Statutory Director of Children's Services; Peter Wilkinson, Acting Director of Public Health; Cllr Caroline Penn (BHCC); Graham Bartlett (Brighton & Hove Local Safeguarding Adults and Children's Boards); Pennie Ford (NHS England); and David Liley (Brighton & Hove Healthwatch).

Contact: **Mark Wall**
Secretary to the Board
01273 291006
mark.wall@brighton-hove.gov.uk

*This Agenda and all accompanying reports are printed on recycled paper*

Date of Publication - Monday, 4 September 2017

# AGENDA

Formal matters of procedure

This short formal part of the meeting is a statutory requirement of the Board

**Page**

**22 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS**

The Chair of the Board will formally ask if anyone is attending to represent another member, and if anyone has a personal and/or financial interest in anything being discussed at the meeting. The Board will then consider whether any of the discussions to be held need to be in private.

**23 MINUTES** **1 - 10**

The Board will review the minutes of the last meeting held on the 1th July, 2017 decide whether these are accurate and if so agree them.

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

**24 CHAIR'S COMMUNICATIONS**

The Chair of the Board will start the meeting with a short update on recent developments on health and wellbeing.

**25 FORMAL PUBLIC INVOLVEMENT**

This is the part of the meeting when members of the public can formally ask questions of the Board or present a petition. These need to be notified to the Board by 12 noon, Wednesday 6 September 2017. Ring the Secretary to the Board, Mark Wall on 01273 291006 or send an email to mark.wall@brighton-hove.gov.uk

**26 CARING TOGETHER - SEPTEMBER UPDATE**

Verbal update from the Executive Director for Health & Adult Social Care and the Accountable Officer for the CCG.

*Contact:* *Rob Persey* *Tel: 01273 295032*
*Dr David Supple* *01273 238783*
*Ward Affected:* *All Wards*

**The main agenda**

Health & Wellbeing

**Papers for Discussion at the Health & Wellbeing Board**

**27 Integration of Health and Social Care: Update**

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|---|---|---|
| *Contact:* | *Rob Persey* | *Tel: 01273 295032* |
| | *Dr David Supple* | *01273 238783* |
| *Ward Affected:* | *All Wards* | |

**Papers for Decision at the Health & Wellbeing Board**

**28 BETTER CARE PLAN** **11 - 66**

Report of the Executive Director for Health & Adult Social Care (copy attached).

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|---|---|---|
| *Contact:* | *Rob Persey* | *Tel: 01273 295032* |
| *Ward Affected:* | *All Wards* | |

**29 BRIGHTON AND HOVE CANCER STRATEGY 2017-2020** **67 - 158**

Report of the Executive Director for Health & Adult Social Care (copy attached).

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|---|---|---|
| *Contact:* | *Becky Woodiwiss* | *Tel: 01273 296575* |
| | *Mari Longhurst* | *01273 239731* |
| *Ward Affected:* | *All Wards* | |

**30 BREASTFEEDING UPDATE REPORT** **159 - 178**

Report of the Executive Director for Families, Children & Learning (copy attached).

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|---|---|---|
| *Contact:* | *Kerry Clarke* | *Tel: 01273 295491* |
| | *Siobhan Hier* | |
| *Ward Affected:* | *All Wards* | |

**Papers to Note at the Health & Wellbeing Board**

**31 SAFEGUARDING REVIEW REPORTS** **179 - 196**

Report of the Independent Chair of the Adult and Children's Local Safeguarding Boards (copy attached).

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|---|---|---|
| *Contact:* | *Graham Bartlett* | *Tel: 01273 290728* |
| *Ward Affected:* | *All Wards* | |

Health & Wellbeing

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

For further details and general enquiries about this meeting contact Democratic Services, 01273 2910066 or email democratic.services@brighton-hove.gov.uk

**Public Involvement**
The Health & Wellbeing Board actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public.

If you wish to attend and have a mobility impairment or medical condition or medical condition that may require you to receive assisted escape in the event of a fire or other emergency, please contact the Democratic Services Team (Tel: 01273 291066) in advance of the meeting. Measures may then be put into place to enable your attendance and to ensure your safe evacuation from the building.

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- You should proceed calmly; do not run and do not use the lifts;
- Do not stop to collect personal belongings;
- Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and

Do not re-enter the building until told that it is safe to do so**.**

Health & Wellbeing

## 1. Procedural Business

**(a) Declaration of Substitutes:** Where Members of the Board are unable to attend a meeting, a designated substitute for that Member may attend, speak and vote in their place for that meeting.

**(b) Declarations of Interest:**

(a) Disclosable pecuniary interests
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members of the Board should seek advice from the Lawyer or Secretary preferably before the meeting.

**(c) Exclusion of Press and Public:** The Board will consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, that the press and public should be excluded from the meeting when any of the items are under consideration.

**NOTE:** Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.

A list and description of the exempt categories is available from the Secretary to the Board.

**4.00pm 11 July 2017**
**Council Chamber, Hove Town Hall, Norton Road, Hove, BN3 4AH**

**Minutes**

**Present**: Councillors Yates (Chair), Barford, Taylor (Opposition Spokesperson) and Page (Group Spokesperson) Adam Doyle, Dr. George Mack; Dr. Manas Sikdar, Dr. David Supple, Clinical Commissioning Group.

**Other Members present**: David Liley Healthwatch, Graham Bartlett, Pennie Ford, NHS England, Pinaki Ghoshal, Statutory Director of Children's Services Rob Persey, Statutory Director for Adult Care, Peter Wilkinson Acting Director of Public Health.

**Also in attendance:** Councillor Miller

**Apologies: Councillor Barnett**

**Part One**

## 10 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

10.1 Councillor Miller declared that he was attending the meeting as a substitute for Councillor Barnett.

## 11 MINUTES

11.1 The minutes of the last meeting held on the 13th June, 2017 were agreed as a correct record and signed by the Chair.

## 12 CHAIR'S COMMUNICATIONS

### Integration of Health and Social Care

12.1 Several months ago the council and the CCG agreed to look at the possibilities of primary, community health and social care services working closer together. A further report will be going to the Policy, Recourses and Growth committee and CCG Governing Body later this month proposing that BHCC and the city's CCG formally take joint responsibility for commissioning local primary, community health and social care services. The recommendation seeks support for developing a single commissioning structure and a new relationship with providers to deliver improved health and wellbeing outcomes for our residents in Brighton and Hove.

12.2 The CCGs across Sussex are considering the steps that need to be taken on the path to strategic commissioning.

12.3 We will update the Board with the outcomes and progress as part of our standing agenda item Caring Together.

**4th July – The Launch of the Big Health and Care Conversation**

12.4 Last week we saw the launch of the Big Health and Care Conversation. Over 130 members of the public attended. In addition over 70 CVS, CCG and council staff and provider staff people came to the Dome and took part in the start of the conversation. Further information of the enjoyable and informative event will come later in the meeting.

**Safeguarding update**

12.5 A Safeguarding Adults Review (SAR) is held when an adult dies as a result of abuse or neglect and there is a concern that partner agencies could have worked more effectively. In March 2017 the Brighton & Hove Safeguarding Adults Board published a SAR. This relates to individual X.

12.6 X was a 59-year-old biological male who also sometimes presented as female and identified as transgender. In December 2014 X was found dead. The Coroner recorded a verdict of 'misadventure to which self-neglect contributed'.

12.7 The SAR was conducted by an independent reviewer and considered multi-agency working in the 12 months leading up to X's death. It identified a need for the LA to ensure a full antecedent history of homeless clients moving into the city is sought, including whether the client is known to be subject to a safeguarding alert elsewhere in the country. It highlights a need to review service user engagement strategies, particularly as they relate to people who are diagnosed with or suspected of having a Personality Disorder. Its calls on the SAB to satisfy itself that partners understand the wider remit and value of Safeguarding Policies and procedures together with their individual agency responsibilities and to assure itself that partners have sufficient understanding of self-neglect as safeguarding issue requiring action under Sussex Safeguarding procedures.

12.8 An action plan is overseen by the SAB SAR subgroup with progress overseen by the SAB.

12.9 One such action was for the SAB to ensure recommendations as they relate to: i) Homelessness ii) mental health iii) community safety contained in the 'Brighton and Hove Trans Needs Assessment 2015', have been fully implemented and meet the required standards of good practice. To progress this action the report was shared with the Communities, Equality and Third Sector Team to review against the current TNA. From here the report was tabled at the NICE Committee on 3rd July. The full report can be found: **https://present.brighton-hove.gov.uk/Published/C00000968/M00006935/$$ADocPackPublic.pdf**

## 13 FORMAL PUBLIC INVOLVEMENT

13.1 The Chair noted that there were no public items to be considered at the meeting.

## 14 CARING TOGETHER - JULY UPDATE

14.1 The Chair suggested that Items 14 and 15 should be taken together and invited Dr. Supple to update the Board and introduce the report listed under Item 15 on the agenda.

14.2 **RESOLVED:** That the information be noted.

## 15 BRIGHTON & HOVE CARING TOGETHER: COMMUNICATION AND ENGAGEMENT STRATEGY

15.1 Dr. Supple noted that a launch event for the STP engagement process had been held on the 4th July, which had gone well but was very much the beginning of the process. He stated that following feedback improvements would be made to the ongoing

consultation process and he hoped that it would provide confidence in that process and a better understanding of what was being planned. There was a need to involve all colleagues across the Health & Social Care Sector and to be mindful that various communication methods would need to be employed as different models suited different people e.g. the need for evening events and roadshows at various locations across the city had been recognised. He noted that there was a level of tension around the city in relation to the process and he hoped this could be addressed by having an honest conversation.

15.2 The Executive Director for Health & Adult Social Care stated that it was intended to collate the information obtained and to report back to the Board in due course.

15.3 Councillor Page stated that there was a degree of frustration in regard to the level of financial information that was available from the CCG and the savings required. He also noted that another surgery was due to close later in the year and queried how it would affect the Better Care Fund.

15.4 The Executive Director for Health & Adult Social Care stated that the Better Care Fund criteria had to be agreed with Health colleagues and officers were in discussion about funding and savings target for the whole of Sussex as well as Brighton & Hove. It was hoped that further information would be available for the Board meeting in September.

15.5 Councillor Barford welcomed the engagement process and thanked those who were leading it and asked that consideration be given to how to engage with the Learning Disability Community and those who did not have English as a first language.

15.6 Councillor Taylor stated that he supported the idea of integration in principle and that everyone could learn from each other. He asked what was planned for engagement with the elderly population and noted that the report to the Policy, Resources & Growth Committee stated there were no financial implications in relation to the Caring Together engagement process, but questioned the cost of officer time and hire of venues.

15.7 The Executive Director for Health & Adult Social Care noted the comments and stated that the report to the PR&G Committee was a direction of travel report and that there would be an intensive period of work in regard to the integration process. He hoped that a further report could then be brought to the Board in the autumn. It was likely that there would be a shadow period prior to full implementation. He was also aware of the need to manage the engagement costs and to give consideration to how engage with various communities.

15.8 The Chair stated that everyone was learning together and the use of the consultation portal would be helpful as part of the engagement process. He therefore asked if the Board was happy to note the report and strategy.

15.9 **RESOLVED:**

(1) That the strategy be noted; and

(2) That the Board should receive regular updates on the communications and engagement strategy, any updates and progress.

## 16 WORKING TOGETHER TO SUPPORT PARENTS WITH A LEARNING DISABILITY

16.1 The Service Manager for the Community Learning Disability team for Adults, Families, Children and Learning introduced the report, which provided an update on the development of joint work between Children and Adult Services to support parents in Brighton and Hove who have a learning disability. He noted that the report also addressed the points raised by the Fairness Commission in relation to the ability of Adults and Children Services to work together to provide a needs led service to families to help support them.

16.2 The Head of Service, Children's Safeguarding & Care stated that a joint protocol had been established and work was underway to develop practice guidance that would sit beneath the protocol and to have shared resources to meet the needs of those with learning disabilities. She also noted that a multi-agency audit was due in 2018/19 and a further report would then be brought to the Board.

16.3 Members of the Board welcomed the report and the actions that had been put in place and noted that options to work with the University of Sussex and the Norah Fry Centre in Bristol. They also noted the support from Impetus and that the concerns of the Chief Executive of Impetus regarding how commitments would be put in place to meet the needs of parents with learning difficulties had been addressed. The Members of the Board also welcomed the intention to bring a further report back in due course as it provided the opportunity to monitor the impact of the changes that had been and were being made to the service.

16.4 The Chair noted the comments and put the recommendations to the vote with an additional recommendation that a further report be brought to the Board after the Adult and Children's Safeguarding Review Boards review.

16.5 Councillor Barford formally seconded the additional recommendation moved by the Chair.

16.6 **RESOLVED:**

(1) That the report be noted and it be agreed that the content fulfils the response to the Fairness Commission;

(2) That it be noted that the joint protocol (appendix 1 to the report), had been established between Children and Adult's Services with regards to services to parents with learning disabilities. It was also noted that the Protocol was awaiting feedback from a key stakeholder and it was planned to go live as of the week ending 14th July;

(3) That the services and support provided to parents who have learning disabilities to enable their parenting be noted; and

(4) That a further report be brought to the Board in 2018/19 following a review by the Children and Adult Safeguarding Boards.

## 17 FOOD POVERTY ACTION PLAN PROGRESS UPDATE

17.1 The Chair referred to the extract from the Neighbourhoods, Communities & Equalities Committee which raised the need to consider the impact of community meals in terms of improving people's care packages. He was aware that a report was due to come to the Board in the autumn and proposed that the report be noted.

17.2 The Executive Director for Health & Adult Social Care noted that concern had been raised about people having their hydration and nutrition needs met and stated that this was taken into account as part of the assessment process.

17.3 Councillor Miller queried how food poverty in schools was taken into account by the food poverty action plan.

17.4 The Executive Director for Families, Children & Learning stated that the Fairness Commission had made a number of recommendations in relation to the School day and two schools were already looking at how those recommendations could be taken into account. He anticipated that schools would be looking at this and further information could be included in the report for the Board in the autumn.

17.5 Councillor Page referred to the Annual Report of the Director of Public Health and the recommendations of the Fairness Commission, and queried whether community meals for and needs of vulnerable citizens were included in social care assessments.

17.6 The Executive Director for Health & Adult Social Care stated that an assessment would take into account hydration and nutrition needs.

17.7 Councillor Barford suggested that those people who paid for care did not generally present for assessment, and there was a need to look at how this could be addressed. She was aware that the council was working with the Food Partnership to promote healthy eating but suggested that more could be done.

17.8 Mr. Liley noted Healthwatch were working with the Food Partnership to set up a Special Interest Group to look at how healthy eating could be promoted, especially in relation to hospital discharge. He would update the Board on the progress at a future meeting.

17.9 **RESOLVED:** That the extract from the Neighbourhoods, Communities & Equalities Committee be noted.

## 18 JOINT STRATEGIC NEEDS ASSESSMENT REVIEW

18.1 The Consultant in Public Health, Brighton & Hove City Council introduced the report which detailed a review of the Joint Strategic Needs Assessment which had been

considered by the Board in 2016. The report set out a proposed programme of in-depth needs assessments for 2017 and sought approval from the Board.

18.2 Members of the Board welcomed the report and noted that air quality was a factor with respiratory deaths being the 3rd highest group in the city. The need to provide a greater level of support to those who live alone was also raised, as this amounted to 41% in the city compared to 30% nationally.

18.3 Dr Sikdar noted that the report detailed the social insight profile and had a comparator with GP clusters national average and asked if in future similar information could be provided for GP clusters on a local level.

18.4 The Executive Director for Health & Adult Social Care noted that the purpose of the JNSA was to look at how services were commissioned to meet needs that had been identified. He noted that significant work was being undertaken with the voluntary sector around social isolation and a policy was being developed for that.

18.5 The Chair noted the comments and moved that the recommendations be agreed.

18.6 **RESOLVED:**

(1) That the 2017 JSNA summary be approved for publication, as set out in section 4.3 and provided in Appendix 1;

(2) That the priorities for in-depth needs assessments in 2017/18 as set out in section 4.4.1 of the report be approved;

(3) That the development programme for the JSNA over the next three years, building on the feedback from the consultation, as set out in section 4.5.7 of the report be approved; and

(4) That officers be requested to continue to develop the JSNA to support the overall approach and whole system development of health and care services, including informing policy and resource allocation.

## 19 WEIGHT MANAGEMENT TIER 2 PROCUREMENT

19.1 The Public Health Specialist introduced the report which set out the plans for the procurement and award of a new contract for weight management services for delivery in Brighton & Hove.

19.2 Councillor Miller noted that the report had been to the Procurement Board and that significant savings had been identified which could be achieved through integration of services.

19.3 The Executive Director for Health & Adult Social Care stated that the aim was to achieve more efficient provision of services and to tackle the issue of obesity.

19.4 Members of the Board noted the information and queried whether referrals could be made from a number of sources and not just GP practices. The need to monitor the performance of contractors was also raised, given that the expectation was that obesity levels would increase initially.

19.5 The Public Health Consultant confirmed that referrals could be made from various sources and noted that the number of children starting and leaving school who were over-weight was levelling-off in the city whereas it was increasing nationally.

19.6 The Chair noted that there was still a lot of work to do and suggested that it would be helpful to include the detail of what was being measured against in future reports. He then put the recommendations to the vote.

19.7 **RESOLVED:**

(1) That the Executive Director for Health & Adult Social Care be granted delegated authority to carry out the procurement and award of a contract for Tier 2 weight management services with a term of three years; and

(2) That the Executive Director of Health & Adult Social Care be granted delegated authority to extend the contract at the end of the three year term with the potential to extend the contract a further two years if he deems appropriate and subject to budget being available.

Note:

19.8 The Chair then adjourned the meeting for a five minute comfort break at 5.40pm.

19.9 The Chair reconvened the meeting at 5.45pm.

## 20 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016/17

20.1 The Acting Director for Public Health introduced the Annual Report and gave a short presentation on the report. He noted that the report entitled, 'Living well in a healthy city' focussed on prevention and covered the period 2016/17.

20.2 Members of the Board welcomed the report and stated that it was informative and encouraged people to improve their lifestyle and to take all aspects of life into account. There was still a need to do better and areas of concern such as the level of young people trying cannabis and alcohol misuse in the city. However, overall the report was excellent and should be promoted as widely as possible and the key messages repeated with the option to take elements of the report to target audiences.

20.3 The Chair thanked the Assistant Director of Public Health for the report and moved that it be noted.

20.4 **RESOLVED:** That the report be noted.

## 21 BON ACCORD NURSING HOME

21.1 The Head of Adult Social Care Commissioning introduced the report which provided an update on the position with Bon Accord Nursing Home following the recently published Care Quality Commission (CQC) inspection report. He noted that following the home being classified as inadequate, officers worked with the provider to support and maintain services.

21.2 The Independent Chair of the Adult Safeguarding Board informed the Board that the matter had been discussed at the Safeguarding Board and that it had been noted quality issues relating to the home sat with the Care Quality Group.

21.3 Members of the Board expressed concerns over the findings and welcomed the actions that had been put in place to support the residents and their families. It was noted that in terms of places for people with dementia and nursing needs, it was a fragile market and consideration needed to be given in regard to how that was managed.

21.4 The Executive Director for Health & Adult Social Care stated that the concerns raised related to a specific care home and officers had made clear the expectations for the provider and staff at the home. In terms of provision across the city, Brighton & Hove was doing well in comparison to the situation across the country. He also noted that an action plan had been agreed which the CQC had to approve and would then review in six months to see if an improvement had been made or could then take further steps.

21.5 Mr. Liley stated that he wished to reassure the Board that the CQC worked closely with Healthwatch England and that locally the CQC had three teams dealing with primary care, hospitals and adult social care including care homes. Healthwatch met with the teams regularly and was keen to work in partnership with them and the council to monitor service delivery and agree a plan of activity such as visiting care homes.

21.6 The Chair noted the comments and the action taken to address the difficulties identified at the home in question. He then moved that the report be noted.

21.7 **RESOLVED:** That the report be noted.

The meeting concluded at 6.45pm

Signed Chair

Dated this day of 2017

*Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.*

## 1. Brighton & Hove Better Care Plan 2017- 2019

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 12th September 2017.

1.3 Author of the Paper and contact details:

Rob Persey, Executive Director for Health and Adult Social Care

Adam Doyle, Accountable Officer, Brighton & Hove Clinical Commissioning Group

Lola BanJoko, Director of Performance, Planning and Informatics
lola.banjoko@nhs.net

## 2. Summary

2.1 The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF). The Spring Budget 2017 announced an additional £2 billion to support adult social care in England. This money is included in the IBCF grant to local authorities (LAs) and therefore included in local BCF pooled funding and plans.

2.2 The legal framework for the Fund derives from the amended NHS Act 2006 (s. 223GA), which requires that in each area the CCG(s) transfer minimum allocations (as set out in the Mandate) into one or more pooled budgets, established under Section 75 of that Act, and that approval of plans for the use of that funding may be subject to conditions set by NHS England. NHS England will approve plans for spend from the CCG minimum in consultation with Department of Health (DH) and Department for Communities and Local Government (DCLG) as part of overall plan approval.

2.3 The BCF guidance states that the Plan has to be formally approved by the Health & Wellbeing Board. However the timeframe for the BCF submission causes a time conflict for our Board dates. The steps for local system approval of the Better Care Plan and subsequent submission to NHS England are listed below with the agreed actions we have undertaken to date.

Table 1: Better Care Plan time line

| action | date |
|---|---|
| Draft plan for review at Integration Board | 26th July 2017 |
| Trajectories and data reviewed and finalised against plan | 27th July 2017 |
| Paper endorsed at Health and Well-being Pre meeting | 23rd August 2017 |
| External NHS and LGA Challenge session with feedback for action | 30th August 2017 |
| Board to be informed of challenge findings, and the action / changes to the Plan that will be made accordingly<br><br>Chair and Executive Director and Accountable Office to discuss any issues raised by Board | no date provided in guidance about feedback date |
| CCG Finance and Performance Committee | 5th September 2017 |
| Executive Director for Health & Social Care with Accountable Officer to undertake final submission in consultation with Chair of Health & Wellbeing Board | 11th September 2017 |
| National submission date | 11th September 2017 |
| Plan formally presented at HWB Board meeting for information | 12th September 2017 |

## 3 Decisions, recommendations and any options

3.1 This report is presented for formal approval.

At the pre meeting of the Board following discussion the Board:

- Agreed the content of the working draft
- Authroised the Executive Director of Health and Social Care to undertake the final submission following consultation with the Chair of the Health & Wellbeing Board and the Accountable Officer
- Provide the Health & Wellbeing Board with the final submission for information as required by the BCF guidance.
- Agreed to a further report coming to the Board in November to provide more details on the monitoring and governance arrangement of the BCF in the light of the integration agenda.

## 4. Relevant information

4.1 Appendix 1 contains the BCF submission made to the DH on 11th September 2017.

4.2 There are key changes to the policy framework since 2016-17 include:

- A requirement for plans to be developed for the two-year period 2017-2019, rather than a single year; and
- The number of national conditions which local areas will need to meet through the planning process in order to access the funding has been reduced from eight to four.

4.3 The four national conditions require:

a. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;

b. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;

c. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and

d. All areas to implement the High Impact Change Model for Managing Transfer of Care

4.4 It is important to note that the BCF submission is not about service change but building on the previous BCF delivery and also providing more capacity in the key delivery areas.

## 5. Important considerations and implications

Legal:

5.1 The Health & Wellbeing Board has responsibility to oversee and monitor the implementation of the local Better Care Fund Plan. The proposals in this report are consistent with this role, including the proposed future report regarding monitoring and governance arrangements.

Lawyer consulted: Elizabeth Culbert Date:17/08/17

Finance:

5.2 The Better Care Fund is a section 75 pooled budget hosted by Brighton & Hove CCG. The 2017/18 budget is £25.350m (including £5.093m iBCF). Future year budget allocations have yet to be confirmed and the iBCF grant will reduce over the next two years. The better Care Fund Plan must be delivered within this budget envelope. Financial performance is regularly reported to the finance and performance board.

Finance Officer consulted: David Ellis Date: 31/08/17

Equalities:

Sustainability:

5.3 The Better Care plan outlines actions to support people in the most appropriate settings aiding timely discharge from hospital and avoiding unnecessary admissions. This will contribute to a more efficient use of resources avoiding unnecessary use of acute hospital settings which are resource intensive in terms of finances and energy usage. This will also minimise patient/carer journeys to and from hospital settings.

The aims and objectives of the strategy have a significant impact on improvements to the health and wellbeing of some of the city's most vulnerable residents.

## 6. Supporting documents and information

Appendix 1: The Better Care Fund submission working draft. The final Plan that is submitted will be tabled at the Board on 12th September and put on the Board web pages.

Better Care

Delivering Better Care in Brighton & Hove



# Brighton and Hove Better Care Plan 2017 - 2019

*Delivering our local strategy for Integration through "Caring Together"*

NHS
Brighton and Hove
Clinical Commissioning Group

Brighton & Hove City Council

# Contents

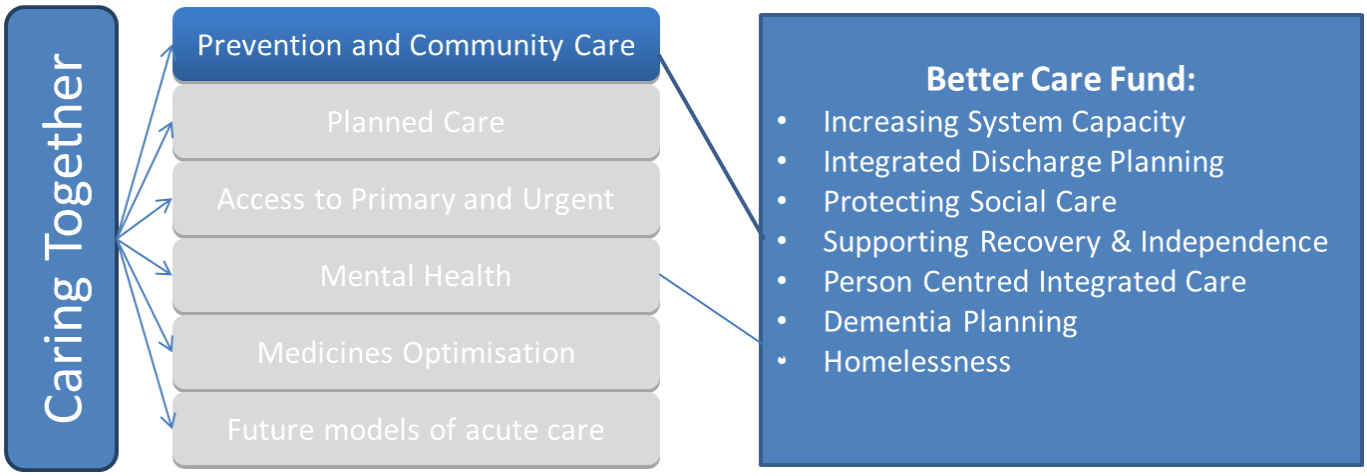
# Introduction / Foreword

- In recent years, the Better Care Fund has been a significant driver in supporting the health economy and City Council in Brighton and Hove to deliver better joined up services to improve both systems working and most importantly patient /service user experience and outcome. As demand on services continues to rise and the pressure on resources continues to increase, we are acutely aware across our partnership of the need to do more at pace. As genuine partners, we are accelerating the delivery of an integrated approach to service commissioning and the Better Care Fund is central to the 'Caring Together' programme for the City. Building upon existing practice, Caring Together is the Brighton and Hove programme to improve local health and social care outcomes for the entire population with the CCG and City Council working closely with Healthwatch, representatives of the local community and the voluntary sector.

Caring Together requires us all to challenge how we can further improve delivery of health and social care in Brighton and Hove providing us with a once-in-a-generation opportunity to put in place a framework for care delivery that sustains for the future the strengths of the past, and maximises the opportunity from new technology and different ways of working, including a renewed focus upon preventative approaches, lifestyle interventions and self-management programmes.

To this end, the recently announced Improved Better Care Fund is a key enabler in delivering the Caring Together vision.. This document sets the Better Care Fund in the local strategic context of Caring Together and as part of that describes the delivery of the required national conditions.

The Better Care Plan is a jointly agreed plan which builds on the first two years of the Better Care Fund. The local fund is made up of £25m allocated to 7 projects (all of which are aligned primarily to the Prevention and Community Programme within Caring Together). The diagram below shows how the Better Care Fund aligns to the Caring Together progamme:




The aim of our Better Care Plan is to deliver a reduction in delayed transfers of care and care home admissions as well as contributing to the delivery of the systems overarching Caring Together outcomes:

- 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

Signatories:

**Brighton and Hove City Council:**

……
Geoff Raw, Chief Executive of Brighton and Hove City Council

**Brighton and Hove Health and Wellbeing Board:**

……
Cllr Daniel Yates, Chair of Health and Wellbeing Board

**Brighton and Hove Clinical Commissioning Group:**

……
Adam Doyle, Accountable Officer of Brighton and Hove Clinical Commissioning Group

……
Dr David Supple, Chair of Brighton and Hove Clinical Commissioning Group

**Healthwatch:**

……
xxx

**Sussex Community Foundation Trust:**

……
xxx

**Brighton and Sussex University Hospital Trust:**

……
xxx

**Sussex Partnership Foundation Trust:**

……
xxx

# Vision for Integration

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 an agreed plan in place by March 2017 for 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. Building initially from the progress achieved by the Better Care programme's focus on frail and vulnerable populations, through a phased approach it will evolve to achieve whole population coverage and improved outcomes across the city placing equal priority on both physical and mental health and wellbeing.

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 are being 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.

We are actively exploring 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. This will be progressed in parallel with a commitment to establish robust and formal alliances that enable working across organisational boundaries to deliver fully integrated and personalised care and support, sharing both resources and risk for the benefits of citizens.

The foundations are largely in place with a number of joint services established already in Brighton and Hove. We do not underestimate the amount of work ahead, however our progress to date provides confidence that by 2020 we will have implemented a programme that delivers:

- 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."

# Background and context

There is a long and successful history of partnership working in Brighton & Hove, with formally shared council/NHS services; close informal partnerships between the council and the NHS; and a thriving partnership structure supported under the umbrella of 'Brighton and Hove Connected', with the council, NHS commissioners and providers, city universities, the police, the fire service, voluntary sector organisations and local businesses working together.

Over the past three years there has been significant engagement across health and care partners in the city to develop a joint vision for integration. This was first articulated in the 2014 Better Care Plan and refined and updated in the 2016 'Statement of Intent'.

The 2014 Brighton and Hove Better Care Plan was co-produced by health and care partners supported by NHS IQ. A period of 9 months facilitated system wide engagement allowed us to develop a collective vision for the delivery of integrated care for our frail and vulnerable population.

In 2015 the local system partners agreed to broaden our ambition from a focus on the frail and vulnerable to a whole population and whole system approach in line with the aspirations set out in the Five Year Forward View. Significant engagement with the community and voluntary sector, providers and partners was undertaken to ensure that the vision and outcomes were collectively designed and agreed. This formed the basis of the 2016 Better Care Plan and subsequent development of Caring Together.

# Progress to date

During the first two years of the Better Care Plan we built solid foundations for delivery of the future model of care. We agreed a governance structure, a clearly articulated collective vision and have delivered the majority (96%) of the milestones set out in our 2014 plan.

In 2016 we developed our Better Care Vision further and have had some notable successes, a few examples of which are illustrated below:

Patients, carers and the public have told us that reliable, accurate and clear information on health conditions, services and sources of support are vital to effective self-management and to empowerment. In response to this:

- Working together across the CCG and City Council, we developed and launched the MyLife online directory at www.mylifebh.org.uk. It provides a "one-stop-shop" for information on health conditions, local health, social care and community and voluntary sector services, and sources of national and local support. It has been promoted widely, and has been very popular with patients/carers/public, clinicians, information and advice providers and support services across the city.

- We have supported a pilot for social prescribing in primary care and are now working to expand this across the city, including developing integrated social prescribing across primary, community and acute (discharge) care settings.

### Homelessness:

Reflecting the national trend, we have increasing levels of homelessness and housing pressure in the City. We have seen homelessness increase by 38 per cent over the last three years. Homeless people often have significantly more multiple health needs which affect their mental and physical health and many of these people will also experience substance misuse issues. The average age of death for the homeless population is dramatically less than that of the average mortality rate across the city. Additionally, it is estimated that the homeless population's A&E attendance rate is five times higher than the average for the City.

To support homeless people, we recommissioned and built on services already provided at the Brighton Homeless Healthcare Surgery in Morley Street. The new service now provides:

- GP services, including a service at the Royal Sussex County Hospital to help provide coordinated care for homeless patients being treated there and to ensure that their healthcare needs are met when they leave hospital;;
- Engagement workers who link in with homeless patients and other local health and care providers and voluntary services and also support homeless people to make decisions about their care;
- Care planning, support and guidance to other local GP practices about managing the needs of their homeless and vulnerably-housed patients;
- 
- Education and training to frontline health staff to raise awareness and understanding of the health and care needs of homeless people. This included training for local GPs and practice nurses and trainee doctors.

### Address long-term illness:

The majority of people aged 75 years and over in the city live with a limiting long-term illness, for example chronic obstructive pulmonary disease (COPD) or diabetes as do a significant proportion of those aged under 75 years (38 per cent of males aged between 65-75 years). Further information on this can be found in the recently published 2016/17 Annual report of the Director of Public Health: Living Well in a Healthy City, available on the City Council and CCG website.

During the year we have established a programme to identify patients who may have COPD. It involves inviting patients who are, or have, been smokers or have other respiratory issues into their GP practice to be screened for COPD. We have also screened patients when they have come to see their GP or practice nurse for another health condition using a short test and questionnaire to identify if they might be at risk.

### Developing care closer to home

Our services need to be designed so they can quickly respond to people when they have an urgent need for support, offering integrated community services as an alternative to hospital admission 24/7.

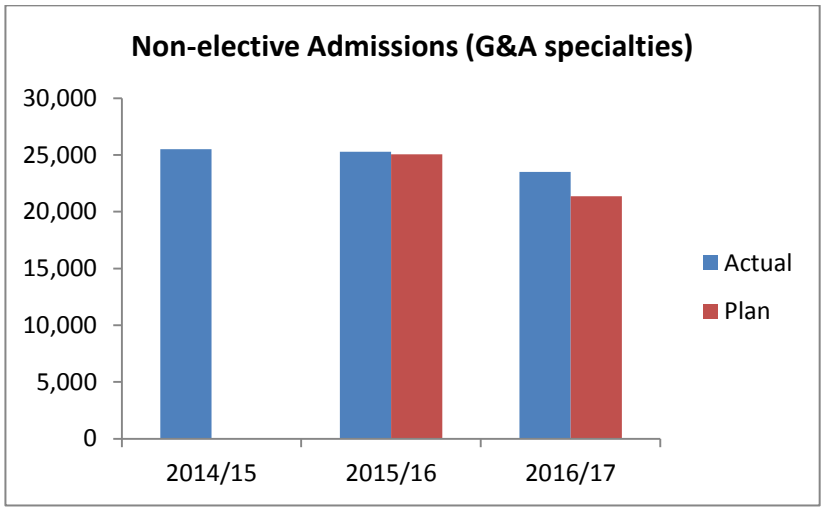
We know that demand for services is increasing and that, coupled with an ageing population, this is likely to continue. Over recent years we have mitigated any increase in the number of A&E attendances and unplanned admissions by developing and strengthening our community services. Our plans for 2016-17 have included a focus upon:

- The development of a single point of access for responsive community teams across the whole of Brighton and Sussex University Hospitals NHS Trust catchment area. This included aligning this model of a "community hub" with the re-procurement of NHS 111, extending rapid response services to provide 24/7 cover, and the
- Development of a system-wide frailty pathway including a single integrated model for community geriatrics.

## Better Care Metrics

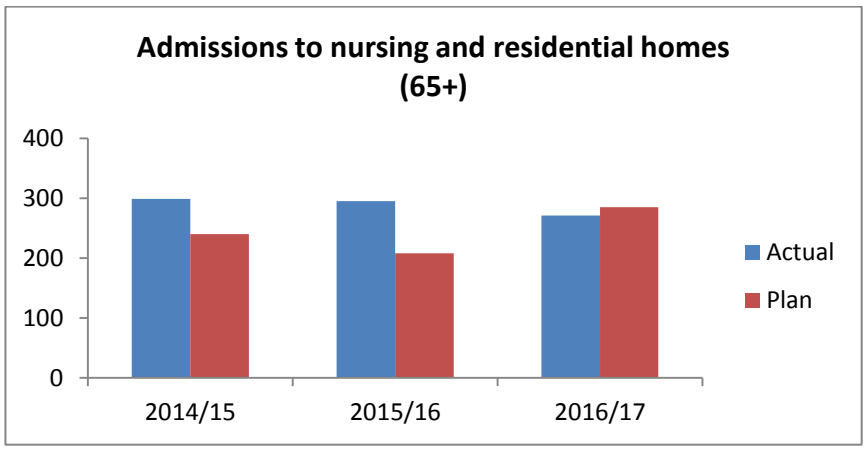
**Non elective admissions:**

In 2016/17 the Better Care Plan set ambitious non elective admission reduction target. This target was not achieved (9% over plan). The CCG Operating Plan 2017-2019 contains a trajectory for non-elective admissions which was agreed by providers and included in contracts for 17-19. There are no additional reductions associated with this Better Care Plan (see page 30).



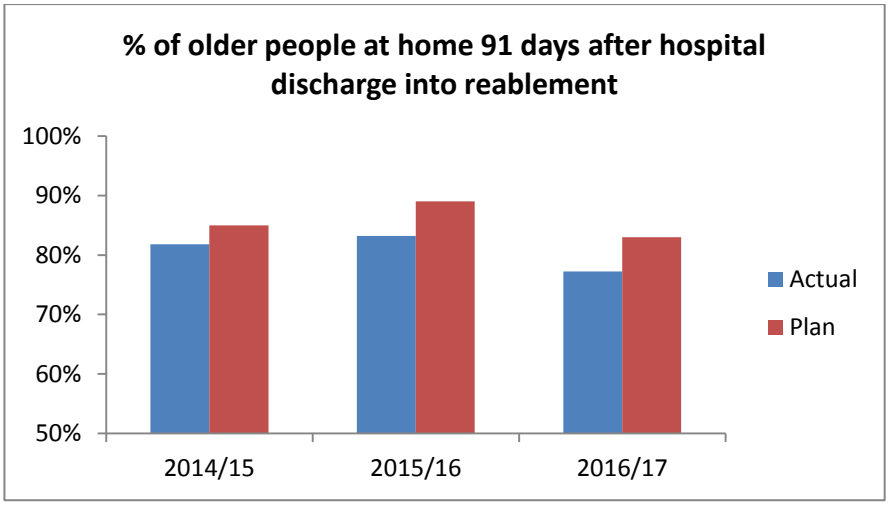

**Care Home Admissions:**

In 2016/17 the Care Home Admissions target to reduce admissions across the year was achieved by 5%:



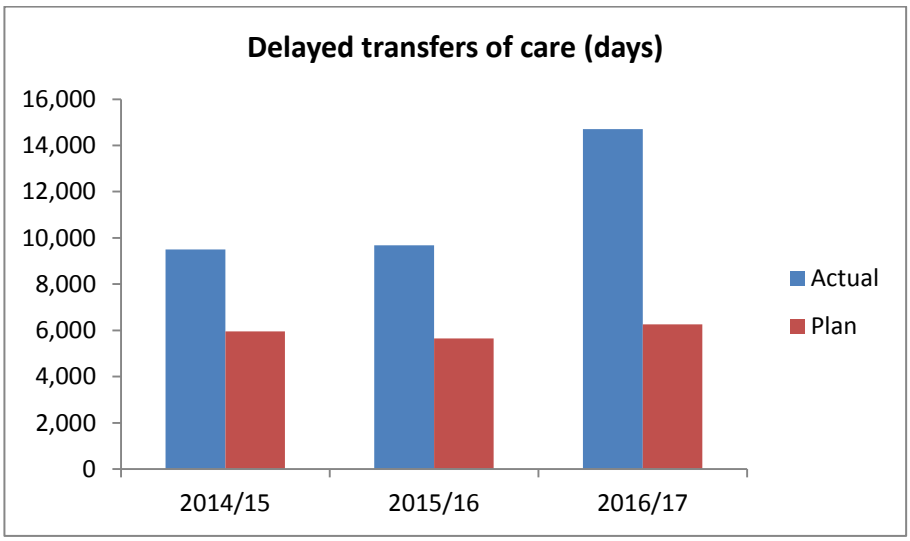

**Reablement:**

The reablement target was missed by 6% in 2016/17. Analysis of the reasons behind this have been undertaken and are being considered in this current years delivery:




**Delayed Transfers for Care:**

During 2016/17 there was a change in the way that delays are recorded locally and a significant improvement in data quality. In addition there was a large increase in actual delayed transfers of care resulting in a large over performance against target. The improvement of delayed transfers of care is the primary focus of this Better Care Plan.




In January 2017, system partners collectively agreed a new approach to the management of delayed transfers of care. The approach taken was to agree operational principles at a system level, apply daily scrutiny of delays by all system partners led at a senior level, ensure data is accurate, real time and consistent, identify single point of accountability, focus on a small number of key areas and to maximize flexibility in the system through commissioning of a combination of block and spot purchase beds and implementation of Home 1st. To lead the implementation and act as the single point of accountability the CCG, on behalf of the system, appointed an interim Director of System Resilience who reported directly to the Chair of the Local A & E delivery board.

As a result of the changes outlined above the system reported a significant reduction in delayed transfers of care at the local Acute Trust (Brighton and Sussex University Hospital Trust) in April and May 2017. The table and chart below show the reduction in the number of days delayed (health and social care):

| Year - Month | BSUH | Grand Total |
|---|---|---|
| 2016-11 | 1,088 | 1,559 |
| 2016-12 | 1,090 | 1,392 |
| 2017-01 | 1,215 | 1,603 |
| 2017-02 | 1,014 | 1,259 |
| 2017-03 | 1,108 | 1,409 |
| 2017-04 | 929 | 1,021 |
| 2017-05 | 746 | 848 |

Table 1: BSUH delays November 16 to May 17

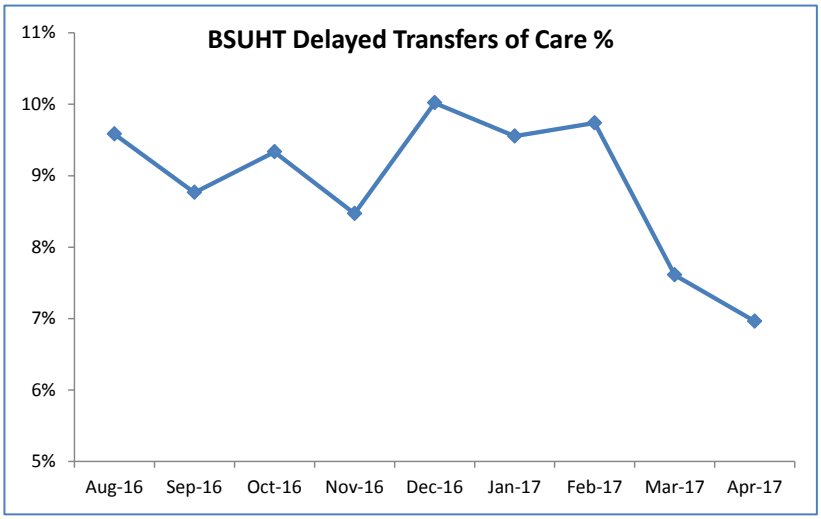


Chart 1: Brighton and Sussex University Hospital trust days delayed August 16 to May 17

We recognise that despite our many successes we were not successful in achieving the ambitious targets we set out in the 2016 Better Care Plan. We have reviewed our historic performance and developed our targets for 2017-19 based on lessons learnt in 2016/17. (see page 29 for details of each of the metrics).

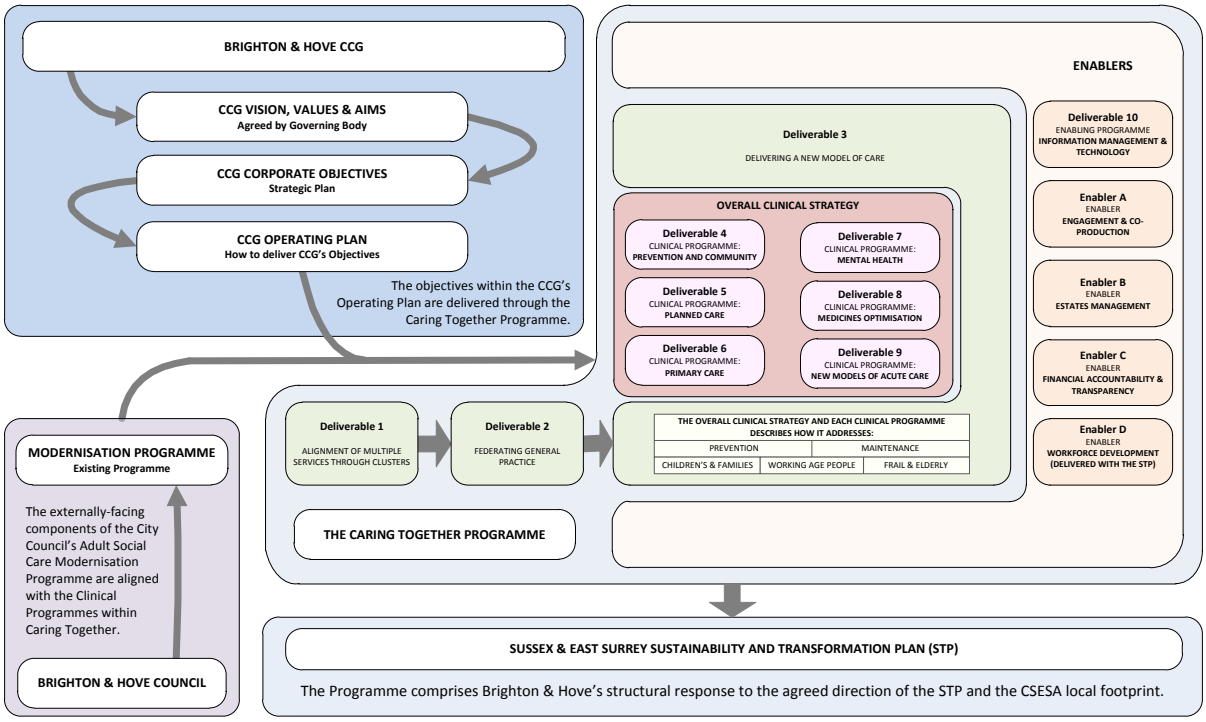
# The Caring Together Programme

As introduced earlier, 'Caring Together' is a programme of delivery bringing 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 Better Care Fund and the majority of the City Council's outward-facing outputs from its Health and 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.*

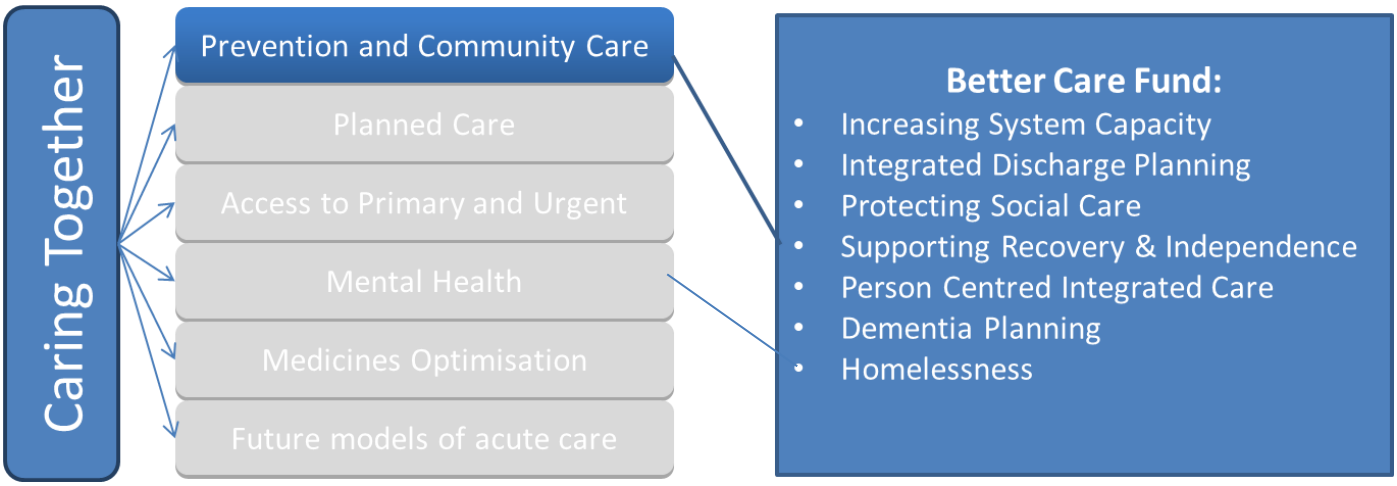



The Programme comprises six programmes

1. Prevention and Community Care.
2. Planned Care services to meet Referral To Treatment
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.

# Better Care Fund

The local Fund is made up of £25m allocated to 7 projects (all of which are primarily aligned to the Prevention and Community Programme within Caring Together). The diagram below, shown earlier on page 3, illustrates how the Better Care Plan links to the delivery of the overarching strategy of Caring Together:




The sections below describe how the delivery of the above Better Care projects will deliver the 4 national conditions (see table below). The accompanying programme plan contains the milestones associated with the delivery of each project listed above and the measures of success.

| | National Conditions | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | 4 |
| | Jointly agreed plan | Social care maintenance | NHS Commissioned out of hospital services | Managing Transfers of Care |
| Increasing System Capacity | ✓ | ✓ | ✓ | ✓ |
| Integrated Discharge Planning | ✓ | | | ✓ |
| Protecting Social Care | ✓ | ✓ | | |
| Supporting Recovery & Independence | ✓ | ✓ | ✓ | ✓ |
| Person Centred Integrated Care | ✓ | | ✓ | ✓ |
| Dementia Planning | ✓ | | ✓ | |
| Homelessness | ✓ | | ✓ | |

# National Conditions

## National condition 1: jointly agreed plan

The Better Care Plan 2017-2019 builds on the achievements and lessons learnt from the previous plan. As described in the opening sections of this plan (see pages 5 and 6) local partners have collectively agreed the following:

- The local vision and model for sustainable systems and better co-ordinated care through the integration of health and social care – this is fully described in our Joint Strategy Caring Together programme.
- A coordinated and integrated plan of action for delivering the vision, see attached milestone plan;
- A clear articulation of how they plan to meet each national condition, see below;
- An agreed approach to performance and risk management, including financial risk management and, where relevant, risk sharing and contingency. See Programme Governance page 27.

## National condition 2: social care maintenance

The table below sets out the Better Care Funding for protecting social care. It includes the grant allocation as part of the improved Better Care Fund and confirms the increase of the contribution by 9.9%

| | 2017/18 Budget | | | |
|---|---|---|---|---|
| **Workstream** | **CCG** | **BHCC** | **iBCF** | **Total** |
| | | | | |
| Home First | 435,379 | 0 | 0 | 435,379 |
| Maintaining eligibility criteria | 2,904,000 | 0 | 0 | 2,904,000 |
| Additional social workers for Access Point | 70,000 | 0 | 0 | 70,000 |
| Protection for Social Care (Capital grants) | 0 | 110,000 | 0 | 110,000 |
| Disabled facilities grant (Capital grants) | 0 | 1,533,131 | 0 | 1,533,131 |
| Telecare and Telehealth (Capital grants) | 0 | 100,000 | 0 | 100,000 |
| Additional call handling resource for CareLink out of hours | 35,000 | 0 | 0 | 35,000 |
| Additional Telecare and Telehealth resource | 200,000 | 0 | 0 | 200,000 |
| Protection for Social Care | 1,189,000 | 0 | 0 | 1,189,000 |
| Supporting Social Care | 0 | 0 | 551,130 | 551,130 |
| | **4,833,379** | **1,743,131** | **551,130** | **7,127,640** |

### Protecting Social Care

Caring Together's vision is for integrated or "joined-up" models of care to support people at home with maximum independence. This approach is expected to benefit individuals and their communities as well as the local health and care economy as a whole.

Protecting social care to meet the needs of vulnerable adults is a key priority for Brighton & Hove City Council. Local adult social care services continue to be supported, maintaining a consistency of approach and in real terms, the level of protection agreed in 2016-17.

Efforts to manage demand through early intervention and asset based approaches to social work are showing early signs of success as we find ways to support individuals to prevent them from needing Adult Social Care Services. Where people do require support - there is an emphasis upon reablement that helps people fulfil their potential and maintain their independence and for partners to ensure effective intervention where there is significant risk to the individual or the community.

In relation to funding this will mean:

- Increased investment in prevention of admission to hospital, earlier but well planned and supported discharge and rapid response services;
- Development and investment in the Home First programme and utilisation of Trusted Assessors;
- Further investment in adult social care to meet statutory need;
- Support for the independent care sector to support timely discharge from hospital;
- Maintaining investment in carers' services including meeting the requirements of the Care Act;
- Further investment in advocacy services in response to the Care Act requirements from April 2015;
- Further development and investment in Information & Advice services to support the preventive approach and ensure compliance with Care Act requirements. 'My Life' Portal in place with links to carers and public self-assessment;
- First phase of Service Redesign completed with increased social work capacity; social work services now aligned with GP clusters.;
- Increased investment in Mental Health Social Work;
- Increased investment in preventative services that delays or reduces potential current and future demand upon services.

## Adult Social Care Services: The Direction of Travel 2016 -2020

The Direction of Travel 2016-2020 remains the vision for Adult Social Care. This is being strengthened and further developed through Caring Together and Better Care Fund resources.

To ensure we achieve our vision we produce the Local Account which links the vision to delivered actions, performance, finance as well as highlighting any challenges or gaps. Our next Local Account is presently being refreshed and will report to the Health and Wellbeing Board in Brighton and Hove in November 2017 as part of the external public monitoring of the process.

We provide an update on performance to Health & Well-being Board (HWB) and Health Overview Scrutiny Committee (HOSC) members (including our CCG and community co-optees) at a quarterly performance review so they are aware of ongoing performance, and provide an ongoing challenge to progress against the vision. The Care Act (2014) provides the statutory framework through which the City Council meets the eligible care and support needs of adults and carers in the city. The Care Act is centred on the personalisation of social care, aiming to maximise independence and give people as much choice and control as possible over their lives. It also establishes clear duties regarding wellbeing, prevention, co-operation between agencies, information and advice, safeguarding, carers rights, assessment and the provision of a diverse high quality social care market place. The legislation provides a positive statutory framework which supports our local aspirations but also sets out the statutory boundaries within which we must operate.

With respect to the budget, the financial context in Brighton and Hove over the next 3 years is extremely challenging. Responding to the reduction in national grant to local authorities, Health and Adult Social Care in the City Council has already delivered £24m savings over the previous 5 years

through efficiencies, service redesign and re-commissioned services and contracts. Further savings of £5.9 million were agreed for 2017/18 as part of the Council's budget setting. Over the next 2 years we are currently anticipating delivering a further saving of £6.0m as part of the integrated service and financial planning process to support the Council to reduce predicted budget gaps.

Having adequate funding for the Health & Adult Social Care pressures remains a challenge despite the additional funding announced through the Spring Budget and ASC precepts. The growing complexity of the client groups, pressures upon the external markets, and increasing numbers of hospital discharges are major factors.

The Better Care Plan delivered through Caring Together provides an opportunity to help local people stay healthy and well, one element of this will involve improved co-ordination and integration of services across the health and social care sector. This also complements an emerging strategic approach gaining support and momentum under the auspices of the Public Health team aiming to cluster future activity under the following headings: Start Well, Live Well, Age Well and Die Well.

A skilled workforce will be essential to the delivery of good quality care services in the coming years and we anticipate this being a challenging issue that we must address. Not only does our current analysis indicate that we have an ageing workforce in the sector with a disproportionate number of staff aged 55 years and over. Also, there is high turnover of staff, many staff are low paid and there are also recruitment and retention issues in relation to professional staff. Additionally, Brexit implications need to be analysed and factored in for the workforce across the health and social care sector. As a high priority therefore, we are currently developing a workforce strategy that will cover the period 2017-20 in order that a skilled and stable work force is in place. This has taken full account of the Ethical Care Charter & the need to consider the National Living Wage for care providers in the city.

Given the context outlined above the key challenges for adult care over the coming years are to deliver good outcomes for local people, achieve financial balance and meet our statutory duties. Our vision for meeting these challenges is visually represented below as a journey and is constructed around 4 key elements outlined below:

**Signposting** - The provision of accessible information and advice to enable people to look after themselves and each other, and get the right help at the right time as their needs change. Good quality information and advice will be available to all to help people plan for the future, reduce the need for care services and where possible maintain independence;

**Stronger communities** – Help build support networks where people live by working in partnership with local health and wellbeing services. This is rooted in the recognition that we are all inter-dependent and we need to build supportive relationships and resilient communities. We will expect to share responsibility with individuals, families and communities to maintain their health and independence;

**Getting people on the right track** – Preventative services that help people stay independent for longer, and support them to recover back to good health after illness. These services will be joined up with and delivered with our partners;

**Citizens in control of their care** - When people do need some extra care and support, services will be personalised, and more joined-up around individual needs. Personal budgets and direct payments are central to this approach.


As explained earlier, these 4 key elements are already in place to some degree and over the coming years there is an opportunity to develop these services further, improve co-ordination and ensure maximum impact. This can achieve better outcomes for people, promoting their independence and well-being. It will also ensure adult social care meets its statutory duties as well as reduce or delay the demand for care and support funded by adult social care services through its community care budget or in house provision.

This is a critical factor in adult social care achieving financial balance as the community care budget is by far the biggest element of adult social care expenditure. Achieving savings to meet budget gaps which are driven by growing demands and inflationary cost pressures, will require providing and commissioning services more efficiently to manage within the available community care budget. The task of providing support to a greater number of clients within a straitened budget is challenging and this is evidenced by data analysis that shows a 7% increase in client numbers since 2012/13 (our baseline assessment for our initial Better Care submission). Delivering this vision is complex, it will require some difficult decisions and the implementation will require excellent partnership working and timely delivery plans. However there are also real opportunities for progress through programmes such as Caring Together, Community Collaboration, City Neighbourhoods and Digital First.

Personalisation is at the heart of the vision outlined above. This includes engaging with local people in service design and development, working with people to assess their individual needs and design support plans, ensuring all eligible service users have a personal budget and people are supported, as the default, to receive this as a direct payment. Essential to this is developing a care market that can respond to people's needs and aspirations and supporting people to use direct payments creatively and collectively within their communities. Delivering this vision is wholly aligned to our duties under the Care Act.

In responding to the changes ahead of us, we will always consider the needs and preferences of the individual, but we will also have to balance this against the effective and efficient use of resources. We must ensure that we have sufficient resources to meet the needs of all people who are assessed as eligible for social care support and we must focus resources on support that prevents delays and reduces the need for care and support.

Given the context and broad vision described above the anticipated direction of travel of adult social care over the coming 3 years is as follows:

### Commissioning

Currently, there are examples where similar services can be commissioned separately by different directorates within the Council and colleagues in the Clinical Commissioning Group. In the near future, with shadow arrangements proposed from April 2018 and full integration from April 2019, services will be subject to integrated commissioning across the Council and CCG with other statutory partners, building on the solid foundation we currently have in place. Further to this:

- Commissioning Leads (CCG/BHCC) are working together on a shared Market Position Statement and joint commissioning intentions to support the shared Caring Together vision.
- We will reduce and delay the demand for long term care in the community by commissioning services that support independence and personal control.
- A wider range of services that promote independence, are outcome focused and support a personalised approach will be in place.
- We will look to commission services in the city that aim to keep people close to their family and communities when they require care and support.
- Citizens and service users will be fully engaged throughout the commissioning process.
- Citizen and patient engagement framed in the 'Big Health and Care Conversation', an ongoing series of engagement events in a range of formats to maximise participation from different groups.
- People in receipt of Direct Payments now have the option of a Pre-paid Card avoiding the need for cash payments, giving greater security and efficiency as well as enabling the Council to better track usage.
- We will further develop our understanding of a fair price for care services in partnership with the care sector.
- Market Sustainability report (presented at Health and Wellbeing Board 31/01/2017) outlined the approach to fee setting acknowledging that services considered were integral to the wider health and care system, which includes managing patient flow in and out of hospital.
- These plans will be further developed through the Caring Together programme

### Assessment Services

With regard to assessment services it is anticipated that over this period:

- The Council's in house assessment services will be increasingly focused on intervention and support for people with the most complex needs and those where the level of risk to the individual or others is assessed as high.
- The in house workforce will be increasingly composed of staff with a social work or other professional qualification and/or relevant experience. We have already invested in additionalqualified social workers across, hospital, community and Mental Health Services. We are also working with local universities to provide opportunities for unqualified staff to train as registered practitioners.
- By deploying mobile technology, for example tablet computers, our staff will be able to complete their assessments directly with people in the community, delivering a more personalised and efficient service.
- Through Leading Places (local strategic partnership with the Universities to support place based working) a Darzi fellow has been funded to further develop use of innovative assistive technologies to support people to self-manage their care reducing reliance on care services.
- Citizens will be supported to complete assessments of need, including an enhanced on-line assessment offer. The support will be proportionate and appropriate and may come from a range of sources including family, community support and the voluntary sector.
- Our approach will be an asset or strengths based one, focusing on what people can do and what they have to offer their community.
- All people who are eligible for services will be offered a personal budget and we anticipate the numbers of people choosing to purchase their own services through Direct Payments will increase significantly.
- In Brighton & Hove, Mental Health services are delivered through an integrated model via a Health Act Section 75 agreement. Hospital Social Work services are fully integrated in the Acute Hospital and alignment of community social work with GP clusters offers opportunities to further develop integrated services to meet need.
- We will enable people to live with the risks that can be inherent in living independently whilst ensuring they are safeguarded from significant and avoidable harm.

### Joint approach to assessments

Assessment pathways have been redesigned as part of the overall service redesign in Adult Social Care with improved documentation, on-line referrals from professionals as well as opportunities for self-assessment.

The Digital First team have worked with the social care Access Point to develop 'Access Point Professionals' which provides a quicker and easier route for health and voluntary sector colleagues to refer for social care intervention and enables more efficient triage of incoming work.

Multi-disciplinary Team (MDT) working is well established in Mental Health services and the Hospital setting, the alignment of Community Social Work with GP clusters has seen a step-change in improved MDT working with Primary care.

We are working on the Trusted Assessor model (see page 25) and our intention is to progress this throughout our service wherever possible. This reduces multiple assessment, produces a quicker care plan and is more timely and responsive. We will be evaluating whether this supports reduction in inappropriate service use and supports improved system performance e.g. Delayed Transfers of Care.

## Improved Better Care Fund: Grant Allocation

The grant allocated to Brighton & Hove City Council over three years is £10.310m. The annual allocations are:

| | |
|---|---|
| 2017/18 | £5.093m |
| 2018/19 | £3.483m |
| 2019/20 | £1.733m |

The government has made it clear that part of this funding is intended to enable local authorities to provide stability and extra capacity in local care systems. Local Authorities are therefore, able to spend the grant, including to commission care, subject to the conditions, as soon as spending plans have been locally agreed with CCGs. The grant has been added to the Better Care Fund, see appendix 3financial schedule, the attached milestone plan and is summarised below.

### Hospital Discharge

- Enhancing the use of assistive technology to facilitate hospital discharge
- The local authority, CCG and acute hospital are committed to a roll out of Home First. The additional resources identified will ensure sufficient assessment capacity to achieve these aims.
- Preventing falls and repeat incidents places increased demand on the acute hospital this initiative will enhance our preventative services in this regard.

### Increasing capacity

- Increased social work capacity to ensure timely assessment and fulfilment of statutory obligations
- To meet increased care needs of eligible people preventing hospital admission and facilitating timely discharge.

### Supporting Social Care

- A identified earlier, Brighton and Hove has a significant issue with homeless people which causes disproportionate demands of health care services and hospital activity. Responding to this, some of the funding has been allocated to target this particular need.
- Increased funding to ensure targeted commissioning to meet the additional demands to support hospital discharge and to prevent hospital admissions

### Safeguarding the most vulnerable people

Safeguard vulnerable people is our highest priority to ensure that we meet our statutory obligations a small part of the funding has been made available to support this.

### Supporting the market

Supporting market diversification through the development and building of capacity within existing homes that can address future demand, increased complexity and support timely discharge from hospital.

## National condition 3: NHS commissioned out-of-hospital services

The Caring Together programme is delivering a priority Prevention and Community work stream focusing on improving the following outcomes:

Outcomes

- Improve health related quality of life for older people
- Reduced social isolation
- Maintaining independence
- Reduced injuries due to falls 65+
- Reduce hip fractures in people 65 +
- Improved Population flu and over 65s vaccination coverage
- Improved early diagnosis rate for dementia
- Improved uptake of NHS Health Checks for people over 65s

Delivering

- Reduce pressure on primary and secondary physical and mental health and care services
- Strengthened community resilience
- Better access to services at more appropriate parts of the pathway: right care, right place, right time (i.e. not in crisis)
- Services to shift their approach to more a preventative and joined up approach
- More productive and empowered older adults
- Better diagnosis and management of long-term conditions including dementia

Reviewing Community Short Term Services provision is the most significant and intensive of any activity within the overall Caring Together Programme. It seeks to redesign the community pathways activity around admission avoidance, supported timely discharge, intermediate care services (step-up and step-down), reablement, and new ways of working including single access arrangements.

This project has been identified as a priority project within the programme and its overall purpose is 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.

- Plans have been agreed to clarify and promote the pathways into the Independence At Home team for people in the community who would benefit from this reablement service.
- On-going discussions with housing services regarding timely access to alternative accommodation in the community. With a new Extra Care scheme in place and a revision of the Housing Allocation policy agreed reflecting the demands on Adult Social Care.
- Plans include the need to respond to increasing numbers of people who initially fund their own care who later become eligible for adult social services when their funds have depleted.
- The increasing complexity of need which can result in care-at-home costs being significantly more than the cost of a residential and nursing home placement. Managers are making case-by-case judgements when considering such circumstances in line with choice protocols.
- Actions to reduce the admissions into long term care residential and nursing home care through alignment of social work provision with Primary Care and roll out of the Home First Programme
- Renewed focus on people admitted from the community. Analysis has shown that over 70% of new long term admissions are from community settings.
- Continue to work with housing colleagues to review the pathways between extra care and sheltered housing and residential / nursing home care.
- Continue to support the delivery of timely housing adaptations via Disabled Facilities Grant.

- Review the arrangements to undertake individual reviews within 6 weeks of placement before any decisions are made about whether the placement should be permanent in nature.
- Continue to support staff in promoting an asset based approach to people's care needs and the alternative options that may assist in avoiding a long term admission to residential and nursing home care.
- Develop more robust performance reporting and analysis in relation to residential and nursing home admissions.
- Further develop existing joint working of the Integrated Primary Care Team, extending integrated working across all clusters.
- Further develop the Risk Stratification tool to enable identification of those at risk of losing independence for targeted multi-disciplinary intervention under the Proactive Care programme.

It is recognised that there are constraints in Brighton and Hove and the wider area on housing provision and access for the various cohorts identified in this plan. For further details on the reporting and management of this risk please refer to Brighton and Hove Council City and Corporate Plans. For additional plan details that support individuals in avoiding admissions to care homes as a permanent place of residence please refer to the CCG Operating Plan.

### Carers - Better Care

Effective support for unpaid Carers is a key priority for the City; carers are arguably our greatest asset within social care and health. Nearly 10% of the population of Brighton and Hove are in a caring role, with 20% of those providing over 50 hours of care per week. It is estimated that the economic value of the contribution made by carers in the City to be £437 million per year. The Supporting Carers Better Care Programme has enabled a truly integrated approach to supporting carers, by building on the previous Better Care pilot projects and promoting greater carer awareness we are commissioning a Carers Hub within the City, to be implemented in October 2017. The Carers Hub supports the 5 priorities within the local Carers Strategy, and ensures that we are responding to our duties to assess, support, and where eligible provide Carers Personal Budgets.

Brighton & Hove CCG & BHCC have jointly worked together to improve carer services in the city.

In 17/18 the Carers Hub will galvanise the dedicated carers services across the City, both within the statutory sector, and voluntary and community sectors, to provide a single access integrated service. The purpose isto act as both a beacon to draw carers to effective support and also to shine a light into the community and raise awareness of carers, ensuring the City is "Carer Friendly". Currently we have a range of services within the 3rd Sector, providing a mixture of Information and Advice, as well as specific support such as free homebased respite to enable carers to attend medical appointments. Additionally, we have ASC Carer Support Workers within each of the ASC Districts/Care Clusters who provide dedicated carer support interventions, and complete Care Act compliant Carers Assessments. The aim of the Hub is to bring together the provision of these services under one access point, enabling greater access to services, and reducing duplication and multiple hand offs.

The Carers Hub outcomes reflects the national direction of integrated approaches to the identification, assessment and support of carers' health and wellbeing needs across health and social care which are to;

- maintain the independence, physical health and emotional wellbeing of carers and their families;
- empower and support carers to manage their caring roles and to have a life outside caring;
- ensure carers receive the right support, at the right time, in the right place; and to

- respect the carer's decision about how much care they will provide and respect the carers decision about not providing care at all.

## Dementia

Brighton & Hove's Joint Dementia Plan 2014/17 sets out the strategic vision for improving care and support to people with dementia and their carers. The central aim of the plan is to increase awareness of the condition, ensuring early diagnosis and intervention.

Since 2013, the dementia diagnosis rate in Brighton and Hove has increased from 43% to 64.3% in June 2017. The CCG has strived to raise the importance of early diagnosis with NHS providers and as a result, more people with dementia have been diagnosed and are able to access dementia care and support services.

In response to the Brighton and Hove Joint Strategic Dementia Delivery Plan 2014-17 and also the Prime Ministers Challenge 20:20 (2015), we will continue to seek to improve health and wellbeing, reduce social isolation and increase support. This will enable people with dementia to remain active in the community longer through enhanced early intervention services and Dementia Action Alliance. We will also continue to increase awareness of dementia, ensuring early diagnosis and intervention and ultimately improve care and support to people with dementia and their carers that is appropriate to their needs.

We will continue to improve greater coordination and integration between services supporting people with a dementia and their carers across the whole pathway. This will be facilitated by improved electronic patient record and information flows and shared dementia care plans across providers. We will continue to focus on improving the quality of inpatient services and the integration with other services in the community and voluntary sector.

The CCG is supporting the implementation of new early interventions and have commissioned Dementia Action Alliance to raise the profile of Dementia, helping to reduce the associated stigma and work with NHS providers, local businesses and organisations, the CCG and County Council to make Brighton and Hove Dementia Friendly.

We have increased support to carers of people living with dementia through the introduction of the Admiral Nurses service and will build on current online resources to ensure a robust and up-to-date electronic dementia information hub that provides information on local support resources is available for people living with dementia, their carers and professionals. Access to respite services will be reviewed and the CCG will strive to ensure capacity is available for all who need it when they need it. Memory Support Workers will continue to support people pre and post diagnosis in the Memory Assessment Service and we will strive to increase capacity in line with increasing numbers of people receiving a diagnosis of dementia.

To increase dementia knowledge and skills of care workers and health professionals caring for people with dementia and their carers, the CCG will build on dementia training programmes that have been delivered to the workforce, ensuring access to a wider independent and community, voluntary and third sector partners.

We will work to ensure that equitable access to care and support is available to people living with dementia in care homes In Brighton and Hove and work with our partners to identify and adopt best practice service models to ensure that people living with dementia and their carers in Brighton and Hove, receive timely services and support appropriate to their needs.

We will strive to ensure that people living with dementia are given the opportunity to complete an Advance Care Plan, early in their dementia journey, to ensure their wishes and preferences for the end of their lives are supported and implemented, facilitating a 'good' death in their preferred place.

### Better Care Pharmacists

The role of the Better Care Pharmacists is to work within the Clusters delivering a clinical pharmacy medication review service aimed at optimising medication use, improving outcomes to patients, reducing medication wastage, advising on prescribing and ensuring prescribing is aligned with local policies and guidelines. Medication reviews are aimed at identifying patients at highest risk of re-admission to hospital and optimising their medicines to reduce medication related readmissions. Between July 2016 - June 2017, the Better Care Pharmacists completed 1,276 medication reviews, delivering a saving of approximately £400k from de-prescribing and admission avoidance to hospital.

Currently all the Better Care Pharmacists are working towards the independent prescriber qualification. During 17/18 the Better Care Pharmacists will be exploring opportunities which help address the high demand in primary care from complex patients e.g. cardiovascular, substance misuse, pain management.

To improve pharmacy the support to general practice and improve outcomes for patients the aspiration for 17/18 will be to continue formalising the Better Care Pharmacists Pharmacy process through;

- Expanding the access to Better Care Pharmacists to those who need it most by creating referral routes from appropriate agencies (e.g. Age UK)
- Prevent hospital readmission and improve quality of life by targeting patients newly discharged from hospital or intermediate care.
- Empowering patients to manage their own conditions by providing education about their medication and their condition
- Continue work on the Medicines Optimisation Programme objectives to deliver savings associated with de-prescribing and hospital admissions.
- In order to support the transfer of care for patients discharged from hospital and reduce delayed discharge from hospital the ambition for the Better Care Pharmacists will be;
- To establish integrated pharmacy pathways and communication between acute and community providers
- Working with acute and community sector pharmacists to establish the role of the Better Care Pharmacists within the discharge process
- Working on developing new models of medication reviews for care home patients to ensure consistency in the access to medication reviews

### Brighton and Hove Integrated Community Equipment Service

In Brighton and Hove community equipment is commissioned jointly by Brighton and Hove Clinical Commissioning Group and Brighton & Hove City Council. This equipment is provided free of charge to people in the community or in care / nursing homes. Equipment ranges from simple items such as a raised toilet seats to more complex items such as hoists.

We respond to patient's requirements and joint partners, in order to enable patients to remain independent and leave hospital ensuring that:

- equipment delivered in convenient time slots;
- excellent communication from the supplier and the driver;

- clear instructions about how to use the equipment and what to do with the equipment when it is no longer needed.

If a patient needs equipment we jointly work with the hospital Trust, occupational therapist, social worker or a nurse will discuss the equipment with the patient and prescribes it. Patients equipment needs are considered at all times with a view to ensuring that patients are able to go home first in line with national policy.

We have a joint programme board which includes providers and active patient participation. We deliver on a joint action plan and report progress to the Health & Wellbeing Board. One of our key successes is monitoring access and we evaluated the service. In 17/18 we will be focusing on recycling and sustainability.

## National Condition 4: Managing Transfers of Care

Local system partners have undertaken a self-assessment against the High Impact Change Model for Managing Transfers of Care. This process has helped us identify our current position and develop actions plans to improve. The table below shows the results of the self-assessment (indicated by ticks) and our aspiration for improvement (indicated by arrows).

| | Change: | Not yet established | Plans in place | Established | Mature | Exemplary |
|---|---|---|---|---|---|---|
| 1 | Early discharge planning | | | ✓ → | | |
| 2 | Systems to monitor patient flow | | | ✓ → | | |
| 3 | Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector | | ✓ → | | | |
| 4 | Home first/discharge to assess | | | ✓ → | | |
| 5 | Seven-day services | | ✓ → | | | |
| 6 | Trusted assessors | | ✓ → | | | |
| 7 | Focus on choice | | | ✓ → | | |
| 8 | Enhancing health in care homes. | | ✓ → | | | |

The following sections provide a brief description of our improvement plan which is contained in full in Appendix 1.

### Early discharge planning

- Implement a new pathway for patient identified as self-funding (Sept 2017)
- Review and streamline how TTO's are prescribed (Oct 17)
- Relaunch the 'Let's get you home' policy (Oct 17)
- Establish robust Length of Stay meetings with clear lines of actions and escalations (Sept 17)

### Systems to monitor patient flow

- There is a close working relationship between agencies and daily multi agency meetings are held at which every patient delay across the system is discussed and resolutions agreed.
- Decisions are recorded electronically and this is sent to all agencies twice daily. These are in addition to daily board rounds and regular MDTs.
- A daily discharge dashboard is available to all agencies.

- Clear rapid escalation process in place to flag individual provider capacity issues (acute, non-acute, social care) up to executive (CEO, CAO) level if required.

### Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector

- Review and reset the MDT agency meetings in BSUH and SCFT (Nov 17)
- CCG support to BSUH with promoting criteria led discharges (Oct 17)
- Reviewing voluntary sector services (contracted and non-contracted) to establish and possibly implement additional timely value for money services
- Promoting quick assessment and turnaround of patients at the front door by implementing primary care streaming (Oct 17)

### Home first/discharge to assess

- CHC process review with service improvements to achieve national target of 85% of assessments being undertaken in the community (Nov 17)
- Home first pilot review and roll out across all wards within RSCH (Nov 17)
- Stimulate and educate care home provider market (Sept 17)

### Seven Day Services

- A number of 7 day services exist across the health and social care system including:
    - Community Rapid Response Services available to support fast track discharge from hospital and admission avoidance 7 days per week
    - Community Short Term Services providing short term reablement care to support people to maximise their independence
    - Access to social work-enhanced social work availability 7 days per week to ensure timely assessment around hospital discharge
- During 2017/18 we will build on the existing services which are proven to deliver value for money and to improve patient experience
- Funding allocated and plans in development to incentivising care homes and homecare providers to respond 7 days

### Trusted assessors

- The Trusted Assessor Model for CHC Fast-Track activity within BSUH Acute Trust was established in summer 2016 and is now fully embedded within the Trust's palliative care pathway

### Focus on choice

- There is an established 'Let's Get You Home' policy, based on the ECIP template, in Sussex agreed between all Health and Social Care acute and community providers and commissioners.
- This was supported by a bespoke campaign for staff and patients, co-designed with them, in winter 2016-17. Posters and leaflets are available in the acute hospitals and are used. Patients and relatives are aware of the policy and letters are used proactively when it appear they would assist in patient discharge.
- The Red Cross and Age UK provide a 'Take Home and Settle Service'.
- The CCG funds a social prescribing service to support patients post discharge, ensuring they are referred into CVS and wider support as appropriate

### Enhancing health in care homes.

- Integrated Care and Social Work aligns work to both STP and locally implemented plans we have developed a way joint way forward with Health, Social Care and Public health forward to focus on our care home provision with a view to improving the services our population receive.

- Working with our system partners we are strengthening community services by building on the action plan produced and by creating a joint care home strategy so that they our commissioning intentions align into account the expectations of our population.
- It is expected that care home provision is remodelled, using the NHS England New Models of Care. We actively work together on a care home programme
- We have jointly agreed to ensure that our projects and programmes of work enhance at all time the patients experience and that we will ensure that we do make sure that if an admission is avoidable then we will ensure that care is delivered closer to home.
- We expect to test ourselves and to be accountable to other by develop an integrated performance dashboard to identify improvements to patients' lives using learning from NHS England best practice as evidenced by Vanguards.
- The CCG continues to support quality care in the community to improve health outcomes to ensure that services that are provided in the community rather than traditional nursing and care settings.

# Overview of funding contributions

The funding contributions are summarised below and contained in Appendices 2&3:

| | | 2017/18 Budget | | | |
|---|---|---|---|---|---|
| **Workstream** | | **CCG** | **BHCC** | **iBCF** | **Total** |
| Increasing System Capacity | | 321,534 | 0 | 2,246,990 | 2,568,524 |
| Integrated Discharge Planning | | 7,761,589 | 0 | 2,053,660 | 9,815,249 |
| Protecting Social Care | | 4,833,379 | 1,743,131 | 551,130 | 7,127,640 |
| Supporting Recovery & Independence | | 3,050,726 | 217,510 | 241,220 | 3,509,456 |
| Person Centred Integrated Care | | 1,512,419 | 0 | 0 | 1,512,419 |
| Dementia Planning | | 209,016 | 0 | 0 | 209,016 |
| Homelessness | | 587,338 | 20,000 | 0 | 607,338 |
| **Total** | | **18,276,000** | **1,980,641** | **5,093,000** | **25,349,641** |

# Programme Governance

Between 2014 and 2016 the Better Care Fund was managed by the Brighton and Hove Better Care Board overseen by the Health and Wellbeing Board. In 2016 the expansion of our ambition required renewed governance which is described below.

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.

# 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.
- workforce challenges across primary, community and acute setting
- Increasing complexity of patients care needs
- Fragility of care market

A risk log is contained within the Caring Together plan.

Financial risk mitigation: If there is any net overspend on the BCF caused by the community equipment store as it is the only variable element of expenditure, this will be shared 50:50 between the council and the CCG

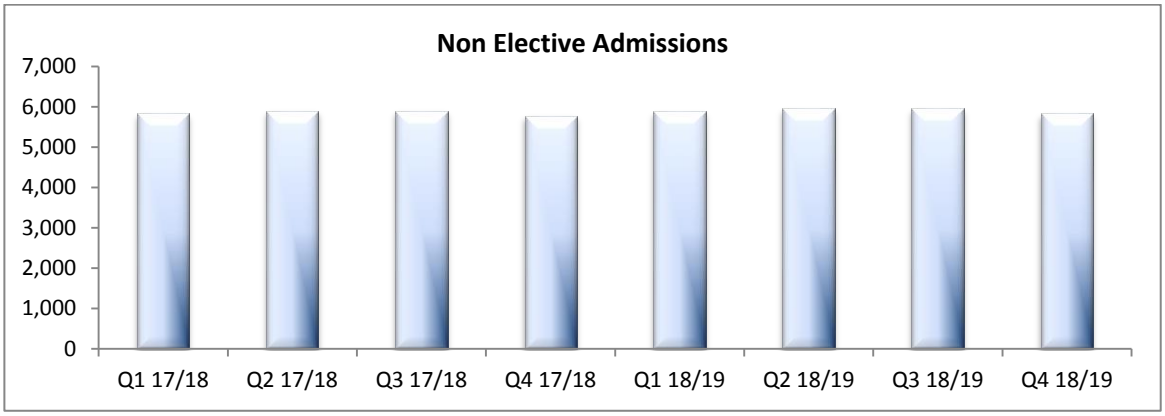
# National Metrics

## Non-elective Admissions (NEL)

In 2016/17 the Better Care Plan set ambitious non elective admission reduction target. This target was not achieved and in fact non elective admissions increased over the period by 9%. The CCG Operating Plan 2017-2019 contains a trajectory for non-elective admissions which was agreed by providers and included in contracts for 17-19. There are no additional reductions associated with this Better Care Plan. The Operating Plan trajectory is contained below for information.

Table 1: Number of non-elective admissions to hospital:

| | Q1 17/18 | Q2 17/18 | Q3 17/18 | Q4 17/18 | Q1 18/19 | Q2 18/19 | Q3 18/19 | Q4 18/19 | Total 17/18 | Total 18/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| NEL | 5,835 | 5,899 | 5,900 | 5,772 | 5,893 | 5,957 | 5,958 | 5,828 | 23,405 | 23,637 |




## Reducing care home admissions and Improving Reablement

National Condition 3 pages 20-25 summarises our plans to reduce care home admissions and improve reablement. Below are the associated trajectories:

Table 2: Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population:

| | 15/16 Actual | 16/17 Plan | 17/18 Plan | 18/19 Plan |
|---|---|---|---|---|
| Annual rate | 835.2 | 742.3 | 647.0 | 589.1 |
| Numerator | 318 | 285 | 250 | 230 |
| Denominator | 38,075 | 38,393 | 38,642 | 39,042 |

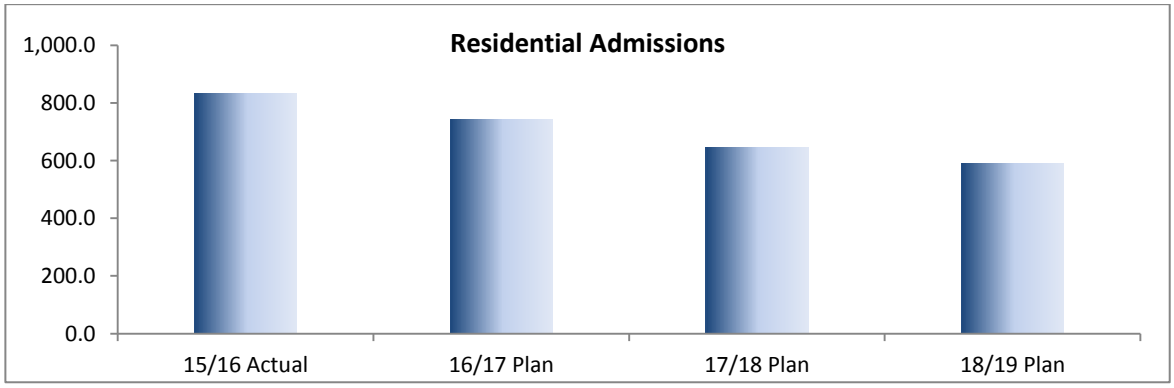
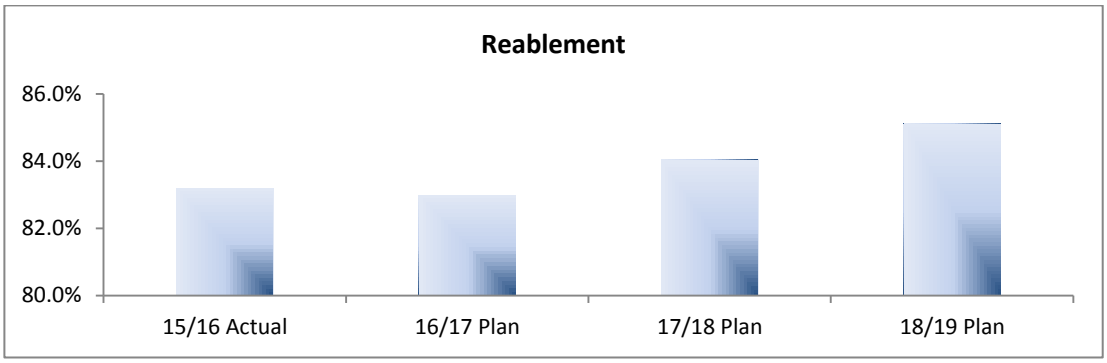


Table 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

| | 15/16 Actual | 16/17 Plan | 17/18 Plan | 18/19 Plan |
|---|---|---|---|---|
| Annual % | 83.2% | 83.0% | 84.0% | 85.1% |
| Numerator | 277 | 278 | 358 | 383 |
| Denominator | 333 | 335 | 426 | 450 |

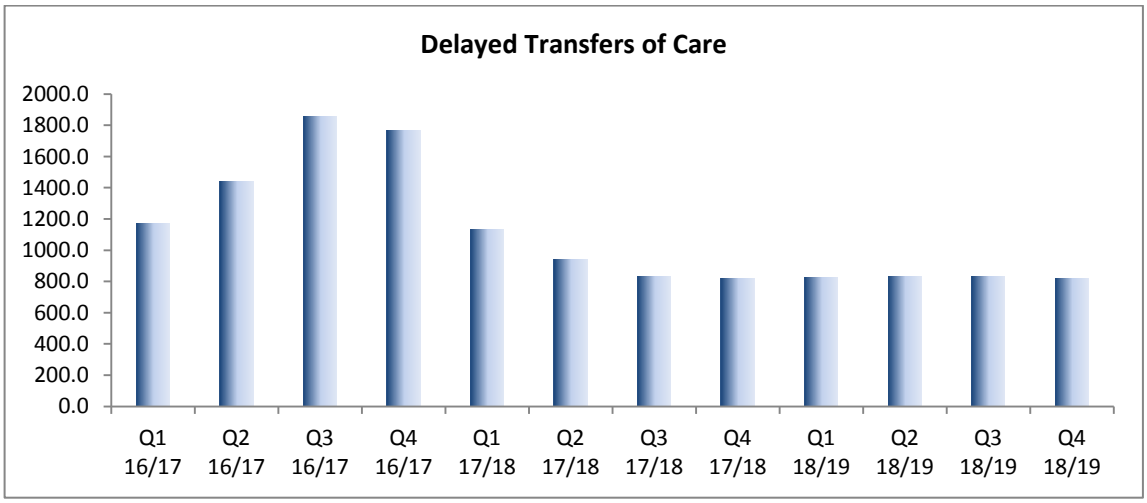



## Delayed transfers of care

The plans to reduce delayed transfers of care are summarised under National Condition 4 pages 25-27 and contained in full in Appendix 1.

Table 4: Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)

| | 17-18 plans | | | | 18-19 plans | | | |
|---|---|---|---|---|---|---|---|---|
| | Q1 17/18 | Q2 17/18 | Q3 17/18 | Q4 17/18 | Q1 18/19 | Q2 18/19 | Q3 18/19 | Q4 18/19 |
| Quarterly rate | 1134.4 | 941.8 | 833.8 | 816.8 | 825.9 | 835.0 | 835.0 | 816.8 |
| Numerator (total) | 2,693 | 2,236 | 1,980 | 1,954 | 1,976 | 1,998 | 1,998 | 1,968 |
| Denominator | 237,431 | 237,431 | 237,431 | 239,269 | 239,269 | 239,269 | 239,269 | 240,994 |




The successful delivery of the better care plan will also be measured through a set of local key performance indicators (see appendix 4)

# Conclusion

The Better Care Plan 2017-2019 confirms the commitment the local system has to meeting the challenges set by the Five Year Forward View. While acknowledging the challenges the local system has faced in terms of the performance, the plan provides solutions to the attainment of a recovered and sustainable future model of care.

# Appendix 1 – Delayed Transfers of Care

| Change: | Where are you now? | What do you need to do? | When will it be done by? | How will you know it has been successful? |
|---|---|---|---|---|
| Early discharge planning | **Medicines**<br>Green bag scheme in place to ensure patients take their medicines into hospital with them. Working with the Lead Pharmacist Medicines in the Acute Sector to ensure patients being discharged from hospital into care homes are referred to the Better Care Pharmacists and Care home medication review team for a review to ensure carers and patients understand any changes to medication. | Establish a formal referral pathway from hospital pharmacy to care home pharmacy review team | September 2017 | Increase in number of patients referred from hospital pharmacists to care home pharmacists<br>Reduction in DTOC by Care homes as result of medication concerns |
| | **Urgent Care:** The Medical Team caring for the patient generally sets the EDD within the first 48 hours of admission. This can change and is used as a guide for the patient and family regarding setting the expectations.<br><br>Electronic white boards are used on the wards to track patient progress in acute hospitals, The EDD/ MRD/ MDT fit dates are recorded on the white boards as well as in the patients notes, and this is where the EDD is considered during the board rounds each day. | Develop a system to ensure that EDDs are monitored and adhered to as appropriate, to prevent deconditioning of patients remaining in hospital for longer than necessary.<br><br>Evaluate communication and reporting mechanisms for tracking patient progress to streamline processes and maximise efficiency | Ongoing<br><br>October 2017 | Reduction in discharge delays (see trajectory contained in appendix 2)<br><br>Reduction in DTOCs (see trajectory contained in appendix 2)<br><br>Reduction in in overall Length of Stay<br><br>Positive self-reported patient outcomes |
| | Well established HRDT- MDT working in ED/ Acute floor.<br><br>Assessment/ 'screen' and DC planning commences quickly<br>Provider led referral hub to provide appropriate | Establish Early Identification programme to improve identification of patients requiring supported DC.<br><br>Build on success of MDT approach (Community Partners and Acute) to proactively work with | October 2017 | Prompt discharge of patients-Improvement in LOS, stranded patient metric and DTOC<br><br>Improved patient experience<br>Reduction in LOS<br>Reduction in stranded patient numbers |

| Change: | Where are you now? | What do you need to do? | When will it be done by? | How will you know it has been successful? |
|---|---|---|---|---|
| | accommodation and care for individual in a timely manner.<br><br>Care Matching team in place to ensure timely sourcing of placements and packages of care.<br>Information available on a daily basis.<br>Community Beds- daily rounds in CV and KH<br>Daily review of all SW allocated work by Senior SW both in acute and community bedded settings | patients to facilitate timely discharge.<br><br>Plans in place to extend Care Matching function to cover all types of packages (including Continuing Health Care funded) | October 2017 | Reduction in social care waiting times<br>Reduction in DTOCs in the community setting<br>Greater market stability |
| **Systems to monitor patient flow** | Local capacity and care pathway demand is reported daily and systems are in place to ensure resources utilised effectively.<br><br>There is a close working relationship between agencies and daily multi agency meetings are held at which every patient delay across the system is discussed and resolutions agreed.<br><br>Decisions are recorded electronically and this is sent to all agencies twice daily. These are in addition to daily board rounds and regular MDTs.<br>A daily discharge dashboard is available to all agencies.<br>Daily CC (12 o'clock)- to:<br>• Exchange clear information regarding all complex/ supported discharges<br>• Ensure prompt escalation where required<br>• Problem solve together<br>• Improved communication and good partnership working | Caring Together Finance and Performance Board and Whole System Reporting groups to continue to work on integrating health and social care activity, outcomes and cost data. Development of more sophisticated statistical trend analysis using predictive analytics to better understand demand and costs across the system and help plan effective resource allocation.<br><br>Continue multi agency approach sharing themes and best practice to improve the system as a whole<br><br>the local system is refining its policy through the learning from experience to further develop plans to match, predict within social care, acute, community and primary care. | By September 2018<br><br>By September 2017<br><br>By September 2017 | Improved data on demand and understanding of patient level costs across health and social care<br><br>Reduction in discharge delays (see trajectory contained in appendix 2).<br><br>Reduction in DTOCs (see trajectory contained in appendix 2)<br><br>Reduction in in overall Length of Stay<br><br>Reduction in DTOC<br>Positive self-reported patient experience<br><br>When the daily discharges are visible to system partners |

| Change: | Where are you now? | What do you need to do? | When will it be done by? | How will you know it has been successful? |
|---|---|---|---|---|
| | HRDT- twice daily team meetings to allocate work/ escalate/ problem solve<br><br>Daily conference call with Social Care Care Matching Team<br>Daily detailed information provided to SW management of all cases at CMT and all cases where SW is involved. This ensures timely escalation and effective monitoring of flow<br>Clear rapid escalation process in place to flag individual provider capacity issues (acute, non-acute, social care) up to executive (CEO, CAO) level if required. | | | Reduction in non-elective admissions<br><br>Reduction in waiting times for social care packages and placements |
| | Falls awareness and prevention project funded/resourced by IBCF, ROSPA and Public Health staffing resource.<br><br>Multi-agency Falls Prevention steering group guiding multidisciplinary approach to falls prevention.<br><br>A set of key shared awareness communications messages agreed across all partners.<br><br>A programme of awareness/prevention training for key services is underway.<br>Specific training for providers of physical activity classes piloted.<br><br>Clarification of signposting and referral routes across and between services. | Recruit Falls Co-ordinator to work with Public Health team.<br><br>Further awareness raising and prevention messages across the H&SC system, Community & Voluntary sector, independent sectors and also with public.<br><br>Build on existing training offering general awareness for all services and more targeted information for those working with older people.<br><br>Further Skills training for those delivering physical activity classes known to help prevent falls /injury through falls e.g. tai chi, yoga, Pilates, some dance,.<br><br>Commissioned Otago and PSI training for more | August 2017 – Oct 2017<br><br>Year1 Nov 2017 – April 2018<br><br>Nov 2017 – April 2018 | Falls Co-ordinator in post 0.4 FTE<br><br>Awareness communications campaign in place and widely used across sectors<br><br>Bespoke training commissioned and rolled out. All placed filled and positively evaluated.<br><br>Bespoke training commissioned and rolled out. All placed filled and positively evaluated.<br><br>3-6 x Strength and Balance classes being delivered in the community each week. Each to include pre and post assessments.<br><br>Establishment of a home safety checks service. |

| Change: | Where are you now? | What do you need to do? | When will it be done by? | How will you know it has been successful? |
|---|---|---|---|---|
| | CCG commissioned NHS Falls Service based within Sussex Community Foundation Trust working with people who have injured themselves from falling or at high risk of injury through falling e.g. people living with osteoporosis | advanced physical activity practitioners to act as alternatives for the NHS service or as a sort of 'step down'.<br><br>Establish Home Safety Checks in partnership with East Sussex Fire and Rescue. Agreed annual number of checks.<br><br>Work with Pharmacists to encourage signposting to physical activity groups etc. when filling prescriptions for medicines known to be associated with increased risk of falls, or for those at higher falls risk due to health conditions.<br><br>Establish methodology for identifying those at high risk of falls in the community. | Pilot Nov 2017 – April 2018. years 2 & 3: April 2018 - March 2020<br><br>Years 2 & 3: April 2018 - March 2020 – pharmacies actively signposting and referrals | Positive feedback from older services users demonstrating their increase in knowledge and confidence of how to prevent falls and injuries from falls.<br><br>Completed assessment of model, achievement of outcomes, financial modelling / cost savings.<br><br>Reduced injuries due to falls 65+<br><br>Reduce hip fractures in people 65 +<br><br>Reduce hospital attendance from falls 65+<br>System in place for signposting and referrals for those identified at higher risk.<br><br>There are shared consistent messages, campaigns and signposting for those who are felt to be at medium to higher risk |
| Multi-disciplinary/multi-agency | Plans for multi-disciplinary/multi-agency discharge teams in place<br><br>**Social prescribing** to support appropriate patients post discharge<br><br>**Pharmacist** included in discharge team review | Create project to review stratification model. Develop interagency project to formalise cluster based teams lead by GPs as part of the care planning processes<br><br>Review the social prescribing service and integrate with other discharge support initiatives.<br><br>Lead Pharmacist Medicine currently on ward MDTs | Aug 18<br><br>Social prescribing review: Oct 17<br><br>Already achieved | Service offer is delivered consistently across the system.<br><br>Increase in patients supported; good self-reported patient outcomes<br>Increased referrals across all settings ( acute, mental health and community) |

| Change: | Where are you now? | What do you need to do? | When will it be done by? | How will you know it has been successful? |
|---|---|---|---|---|
| | | Develop a fully integrated service with robust referral pathway to pharmacists in the community including care home medication review team | | |
| **Home first** | Homefirst programme in place and current pathways being evaluated pending expansion | Evaluate Homefirst evidence and outputs. Develop plan to expand model to 13 wards ensuring that home first becomes the default way of working and embedding trusted assessment. | Evaluation: Aug 17<br><br>Roll out: Sep 17 | Service offer is delivered consistently across the system<br><br>Reduction in LOS.<br><br>Reduction in DTOC (completion of assessment reason and awaiting packages of care across acute, mental health and community setting) |
| **Seven-day services** | A number of 7 day services exist across the health and social care system including:<br>-Community Rapid Response Services available to support fast track discharge from hospital and admission avoidance 7 days per week<br>-Community Short Term Services providing short term reablement care to support people to maximise their independence<br>-Access to social work-enhanced social work availability 7 days per week to ensure timely assessment around hospital discharge | Build on the existing services which are proven to deliver value for money and to improve patient experience – currently Social workers are available 7 days per week .We need to develop Community services including therapies across the system to maximise workforce output. To build enhance access in primary care<br><br>Funding allocated and plans in development to incentivising care homes and homecare providers to respond 7 days | Baseline: Aug 17<br><br>Plan: Sep 17 | Increased number of discharges over the weekend from acute, mental health and community settings<br><br>Reduction of DTOC on a Monday |
| **Trusted** | The Trusted Assessor Model for CHC Fast-Track activity within BSUH Acute Trust was established in summer 2016 and is now fully embedded within the Trust's palliative care pathway<br>.<br>This has contributed to a fast-track eligibility | The CCG aims to work with local partners to introduce a new model pre-checklist screening based on the '5 Qs care' model implemented in West Norfolk in 2016. This will be piloted by the CCG in 2017/18 initially in parallel with the existing checklist process. Evidence from West Norfolk | Agree the 5Q model with partners – Sep 17<br>Pilot – | A reduction in the number of [Non fast track ] DsT's being delivered in the acute which result in an outcome of being ineligible ( 232 DsT's with a 92% of non- eligible for Q4 2016/17) |

| Change: | Where are you now? | What do you need to do? | When will it be done by? | How will you know it has been successful? |
|---|---|---|---|---|
| | conversion rate for Q4 2016/17of 97.3% for BHCCG. This rate is both above the National rate (96.1%) and Right Care comparative CCG rates (96.7%) | indicated a reduction in CHC assessments in the acute setting and a reduction in CHC delayed transfers of care (DTOC)<br><br>To that end the use of the 5Q's care model is the primary area of focus for B&H CHC and not the wider roll of the Trusted Assessor model into the Acute Trust.<br>The other area of focus is the movement of Decision support Tool assessment activity from the Acute Trust into a community setting (either within a patient's own home or in a community short term bed – accessed via our existing referral pathways) and in so doing to achieve within Q4 the 85%/15% division with 85% being within the community and 15% or less being within an Acute setting. | Sept/Oct 17<br><br>CHC checklist – Oct 17 to Mar 18<br><br>Review Jan Feb 18<br><br>Determine 18/19 Feb | 85% of CHC assessments to be undertaken outside of the acute hospital setting by end of March 2018 in line with NHSE targets<br><br>0% Delayed Transfers of Care due to CHC funding decisions by March 18 |
| Focus on choice | There is an established 'Let's Get You Home' policy, based on the ECIP template, in Sussex agreed between all Health and Social Care acute and community providers and commissioners.<br><br>This was supported by a bespoke campaign for staff and patients, co-designed with them, in winter 2016-17. Posters and leaflets are available in the acute hospitals and are used. Patients and relatives are aware of the policy and letters are used proactively when it appear they would assist in patient discharge.<br><br>The Red Cross and Age UK provide a 'Take Home and Settle Service'. | Regular staff training and updating sessions will help to ensure the policy continues to be used widely and proactively.<br><br>The STP have commissioned a second phase of the 'Let's Get You Home' Campaign for winter 2017-18, aimed at engaging staff, patients, and carers further in their awareness and implementation of the policy.<br>Further rollout of Let's Get You Home policy across Mental Health and Community settings<br><br>Embed Red Cross and Age UK 'Take Home and Settle Service' within community services providing reablement beds and services. | September 2017<br><br>By September 2017<br><br>Continuing awareness raising | Reduction DTOC (patient or family choice reasons across acute, mental health and community setting)<br><br>Reduction in DTOCs<br><br>Reduction in in overall Length of Stay<br><br>Numbers of patients seen by the service increases<br><br>Positive self-reported patient outcomes<br><br>Decreased re-admission to acute care |

| Change: | Where are you now? | What do you need to do? | When will it be done by? | How will you know it has been successful? |
|---|---|---|---|---|
| | | The CCG is looking at jointly contracting with local private sector companies to provide services specifically designed to assist and support self-funded patients. | By October 2017 | Reduction in proportion of DTOCs attributed to patient and/or family choice |
| | The CCG funds a social prescribing service to support patients post discharge, ensuring they are referred into CVS and wider support as appropriate | Evaluation of befriending, navigation and health training services will be undertaken to redefine social prescribing and embedded within the suite of services that support effective discharge and post discharge support | By October 2017 | Improved Health related quality of life for people with LTCs<br>Evaluation –success matrix to be developed as part of the evaluation and agreed across all stakeholders |
| Enhancing health in care homes. | **Plans in place – see appendix 3 for Care Home benchmarking.** | Evaluate care home services on offer | Baseline: Aug 17<br>Plan: Sep 17 | Joint plan agreed via CATO- |
| | **Medication review** service in place provided by a team of pharmacists and technicians | Improve the education and training package for staff working in care/nursing | Nov 17 | For the medication reviews we already have a robust commissioned service in place supported by quarterly reports on activity and outcomes. The outcomes are number of interventions actioned, number of medicines optimised, hospital |
| | **Hydration and nutrition support:** Currently homes have access to community dietetics support and Speech and Language Therapy (SALT). However opportunities exist to improve this particular around improving the capacity and capability of Care homes this is being addressed with the recruitment of a lead dietitian for primary care | Lead dietitian recruited. The dietitian will develop a plan ensuring all care homes have access to dietitian support.<br><br>Patients on Oral Nutritional Supplements (ONS) will be reviewed to see if Food First can be adopted instead. GPs and home staff will be educated on the need for food first including techniques and fortification methods, working | December 2017- dietitian in post | |

| Change: | Where are you now? | What do you need to do? | When will it be done by? | How will you know it has been successful? |
|---|---|---|---|---|
| | | alongside the SALT team. | | |
| | There are established plans and systems in place in terms of Community and primary care support, i.e. it is provided to care homes on request – this is provided by both commissioned community services (from SCFT) as well as GPs.<br>There are examples of a small number of Homes having an individual contractual arrangement with GP practices which outlines more structured support the Practice will provide to the Home. However we recognise there is variation in consistency of support and some Homes interface with a number of Practices<br>There is a plan in place to provide dedicated support to high referring homes (provided both by community teams commissioned to support Homes for a range of clinical services, e.g. continence support/management, falls preventions, end of life care etc.), so the support can be tailored to the identified need for each Home.<br>There are more mature systems in place in terms of health and social care support to Homes, based on historic collaborative working between CCG and ASC quality and safeguarding teams. This has been recognised as exemplar practice by CQC and it is reflected in low number of 'inadequate' ratings in the Brighton & Hove area. | Implement vanguard learning locally linked to patient choice on their GP. All patients have named GP and access to wider Primary care services. However it would be more efficient if there is a named Practice per Home<br><br>Work with ambulance service to identify outlier Homes with high frequency hospital admissions, broken down by reasons for conveyance.<br><br>Increase in capacity to prevent admission: Additional funding for Living Well scheme -Care Managers attached to telecare service offering early intervention to support people to maintain independence including those with early onset Dementia.<br><br>In order to provide additional support to the Homes, the CCG is scoping telehealth pilot options for the Homes in line with new models of care approach | March 2018<br><br>October 2017<br><br>Proposed Telehealth pilot November 2017 | Consistency in primary care support reported by Homes.<br>Reduction in delays initiated by care homes<br><br>Information governance issues resolved, i.e. the CCG will have clinical reasons for conveyance in addition to existing data on numbers of admissions. Also evidenced by visits to targeted Homes by CCG Clinical Quality Manager and/or community teams to undertake gap analysis/support needs for individual Homes.<br><br>Reduction in non-elective attendances for pilot care homes |

# Appendix 2 – Better Care Fund 2017/18

| | | 2017/18 Budget | | | |
|---|---|---|---|---|---|
| | **Workstream** | **CCG** | **BHCC** | **iBCF** | **Total** |
| | | | | | |
| Increasing System Capacity Workstream | | | | | |
| | Additional Care Managers working across the City localities 7 days pw | 117,732 | 0 | 0 | 117,732 |
| | 3 Social Workers in IPCT's | 103,228 | 0 | 0 | 103,228 |
| | Integrated Primary Care Teams (SPFT) Additional Mental Health nurses | 100,574 | 0 | 0 | 100,574 |
| | Increasing capacity | 0 | 0 | 1,672,700 | 1,672,700 |
| | Supporting the market | 0 | 0 | 574,290 | 574,290 |
| **Total Increasing System Capacity Workstream** | | **321,534** | **0** | **2,246,990** | **2,568,524** |
| | | | | | |
| Integrated Discharge Planning Workstream | | | | | |
| | Integrated Primary Care Teams (SCT) | 7,710,401 | 0 | 0 | 7,710,401 |
| | Incentivising care homes and homecare providers to respond 7 days pw | 51,188 | 0 | 0 | 51,188 |
| | Hospital Discharge | 0 | 0 | 2,053,660 | 2,053,660 |
| **Total Integrated Discharge Planning Workstream** | | **7,761,589** | **0** | **2,053,660** | **9,815,249** |
| | | | | | |
| Protecting Social Care Workstream | | | | | |
| | Home First | 435,379 | 0 | 0 | 435,379 |
| | Maintaining eligibility criteria | 2,904,000 | 0 | 0 | 2,904,000 |
| | Additional social workers for Access Point | 70,000 | 0 | 0 | 70,000 |
| | Protection for Social Care (Capital grants) | 0 | 110,000 | 0 | 110,000 |
| | Disabled facilities grant (Capital grants) | 0 | 1,533,131 | 0 | 1,533,131 |
| | Telecare and Telehealth (Capital grants) | 0 | 100,000 | 0 | 100,000 |
| | Additional call handling resource for CareLink out of hours | 35,000 | 0 | 0 | 35,000 |
| | Additional Telecare and Telehealth resource | 200,000 | 0 | 0 | 200,000 |
| | Protection for Social Care | 1,189,000 | 0 | 0 | 1,189,000 |
| | Supporting Social Care | 0 | 0 | 551,130 | 551,130 |

| | | 2017/18 Budget | | | |
|---|---|---|---|---|---|
| | **Workstream** | **CCG** | **BHCC** | **iBCF** | **Total** |
| **Total Protecting Social Care Workstream** | | **4,833,379** | **1,743,131** | **551,130** | **7,127,640** |
| | | | | | |
| Supporting Recovery & Independence Workstream | | | | | |
| | Community Equipment Service | 2,077,283 | 15,497 | 241,220 | 2,334,000 |
| | Carers Reablement Project | 14,930 | 0 | 0 | 14,930 |
| | Alzheimer's Society – Information, Advice and Support for Carers | 21,328 | 0 | 0 | 21,328 |
| | Alzheimer's Society – Dementia Training for Carers | 4,266 | 0 | 0 | 4,266 |
| | Sussex Community Trust – Carers Back Care Advisor | 29,035 | 0 | 0 | 29,035 |
| | Amaze – Carers Card Development | 8,531 | 0 | 0 | 8,531 |
| | Carers Centre – Adult Carers Support | 64,000 | 40,000 | 0 | 104,000 |
| | Carers Centre – Young Carers Support | 16,000 | 16,000 | 0 | 32,000 |
| | Crossroads – Carers Support Children and Adults | 40,097 | 0 | 0 | 40,097 |
| | Carers Centre – End of Life Support | 8,105 | 0 | 0 | 8,105 |
| | Amaze – Parent Carers Survey | 853 | 0 | 0 | 853 |
| | Crossroads – Carers Health Appointments | 31,992 | 0 | 0 | 31,992 |
| | Hospital Carers Support – IPCT Carers Support Service | 23,034 | 0 | 0 | 23,034 |
| | Carers Support Service - Integrated Primary Care Team (ASC Staff) | 79,490 | 0 | 0 | 79,490 |
| | Carers (other) | 337,107 | 90,013 | 0 | 427,120 |
| | Carers Hub | 294,675 | 56,000 | 0 | 350,675 |
| **Total Supporting Recovery & Independence Workstream** | | **3,050,726** | **217,510** | **241,220** | **3,509,456** |
| | | | | | |
| Person Centred Integrated Care Workstream | | | | | |
| | Proactive Care (Primary Care) | 1,207,000 | 0 | 0 | 1,207,000 |
| | Care Navigation Service | 134,794 | 0 | 0 | 134,794 |
| | Befriending - Neighbourhood Care Scheme | 170,625 | 0 | 0 | 170,625 |
| **Total Person Centred Integrated Care Workstream** | | **1,512,419** | **0** | **0** | **1,512,419** |
| | | | | | |
| Dementia Planning Workstream | | | | | |
| | Dementia Plan | 209,016 | 0 | 0 | 209,016 |
| **Total Dementia Planning Workstream** | | **209,016** | **0** | **0** | **209,016** |
| | | | | | |
| Homelessness Workstream | | | | | |

| | | 2017/18 Budget | | | |
|---|---|---|---|---|---|
| | **Workstream** | **CCG** | **BHCC** | **iBCF** | **Total** |
| | Homeless Model | 587,338 | 20,000 | 0 | 607,338 |
| **Total Homelessness Workstream** | | **587,338** | **20,000** | **0** | **607,338** |

| | | | | | |
|---|---|---|---|---|---|
| **TOTAL** | | **18,276,000** | **1,980,641** | **5,093,000** | **25,349,641** |

# Appendix 3 - Improved Better Care Grant Allocation

| Description | 2017/18 £'000 | 2018/19 £'000 | 2019/20 £'000 | Grant Conditions |
|---|---|---|---|---|
| Maintain and Increase financial commitment to community short term care | 650 | 650 | 650 | 1,2,3 |
| Sustain adult social care services in maintaining service standards in the context of increasing demand | 1,000 | 2,000 | 2,000 | 1,2,3 |
| In house Older People resource centres – Wayfield Avenue Lodge and Ireland Lodge | 121 | 121 | 121 | 1,2,3 |
| West Pier hostel | 218 | 218 | 218 | 1,2,3 |
| Commissioning & Performance | 130 | 130 | 130 | 1,2,3,4 |
| Carelink equipment and expansion | 50 | 230 | 230 | 1,2,3,4 |
| Safeguarding staffing & reviews | 49 | 25 | 25 | 1 |
| Transforming out of Hospital Social Care/Home First | 123 | 164 | 164 | 1,2,3 |
| Additional assessment and move on | 154 | 205 | 205 | 1,2,3 |
| Training to support above | 10 | 0 | 0 | 1,2,3 |
| Access point support from the voluntary sector | 30 | 0 | 0 | 1,4 |
| Rough Sleepers Strategy | 34 | 45 | 45 | 1,2,3 |
| Autism Strategy | 50 | 50 | 50 | 1 |
| ECMS/DPS Costs | 65 | 65 | 65 | 1,2,3,4 |
| Supporting market diversification | 250 | 250 | 250 | 1,2,3,4 |
| Falls Prevention | 50 | 50 | 50 | 1,2,3 |
| Health Trainers | 90 | 90 | 90 | 1,2,3 |
| Community Equipment Store | 241 | 0 | 0 | 1,2,3 |
| Increasing social care capacity | 1,778 | 0 | 0 | 1,2,3 |
| Total use of grant | 5,093 | 4,293 | 4,293 | |
| Grant allocation | -5,093 | -3,483 | -1,733 | |
| Shortfall in funding | 0 | 810 | 2,560 | |

# Appendix 4 – Local Key Performance Indicators

| Project | Local KPI |
|---|---|
| Increasing System Capacity | Social Care Delayed Days per day per 100,000 18+ population<br>Delayed Days per day per 100,000 18+ population (awaiting completion of assessment)<br>Delayed Days per day per 100,000 18+ population (awaiting residential home placement or availability)<br>Delayed Days per day per 100,000 18+ population (awaiting nursing home placement or availability)<br>Delayed Days per day per 100,000 18+ population (awaiting care package in own home) |
| Integrated Discharge Planning | % of older people at home 91 days after hospital discharge into reablement<br>Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services<br>Delayed transfers of care (days)<br>% Emergency readmission within 30 days of discharge from hospital (B&H CCG)<br>Average Length of Stay for older people (65+) |
| Protecting Social Care | Proportion of support plans that have a % telecare as a component<br>Telecare service user satisfaction (95% target)<br>Number of people supported through Telecare (620 per annum)<br>% of users receiving long-term community support who received self-directed support<br>% of users receiving long-term community support who received direct payments or part direct-payments<br>% of equipment delivered/collected in time<br>% of adult social care users who have as much social contact as they would like |
| Supporting Recovery & Independence | % of carers receiving carer specific services who received self-directed support<br>% of carers receiving carer specific services who received direct payments or part direct-payments<br>% of adult carers who have as much social contact as they would like |
| Person Centred Integrated Care | Non-elective Admissions (G&A specialties)<br>Admissions to nursing and residential homes (65+)<br>Percentage of patients receiving a Whole Person Assessment against the roll-out plan (v3)<br>% of Proactive Care patients received face-to-face appointments within 4 weeks<br>Average Length of Stay for older people (65+) |
| Dementia Planning | Dementia Diagnosis rate<br>Face to face follow up within 12 months |
| Homelessness | Percentage of people moving on from Homeless Support Services to more independent living (in past 12 months) |

# Appendix 5 – Supporting papers

The following provides supportive evidence to the content of the Plan.

**Vision for Integration and Progress**

The Council and CCG have been working on integration of services for some time. Papers have gone through both the CCG GB and Council to outline the integration agenda. The following links provide some of the external reporting:

December 2016 report through Policy Resources & Growth Committee (PR&G)

https://present.brighton-hove.gov.uk/Published/C00000912/M00006399/AI00055103/$20161117092954_009996_0040600_HealthSocialCareIntegrationPRGReportDec16.docxA.ps.pdf



a further report was provided in July 2017

https://present.brighton-hove.gov.uk/Published/C00000912/M00006703/$$ADocPackPublic.pdf

A report is also due to go to PR&G in October 2017.

**Evidence for Integration**

The Health & Wellbeing Board (HWB) have had a standing agenda item on Caring Together which also covers the content of Better Care. This item has been increase to include updates on Integration. The following link takes you to the HWB papers.

https://present.brighton-hove.gov.uk/mgCommitteeDetails.aspx?ID=826

There has been a Cross Party members working group that have been meeting to support the officer work. This has been held in private and is not a meeting in public.

A report to the HWB in September will include significant detail about the evidence for integration which builds on the work from the DPH 2014 – 2015 report to the HWB provided the back drop to what the demands for services could be in 2024.

https://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove/annual-report-director-public-health-2014-15

Further evidence was reported in 2016 – 2017 DPH report

https://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove

which again has gone through the Board.

**Caring Together Programme**

Caring Together has been a standing item at the HWB since June 2016 and also part of the Big Health & Care Conversation

https://www.brighton-hove.gov.uk/event/big-health-and-care-conversation-launch-event

https://present.brighton-hove.gov.uk/Published/C00000826/M00006663/$$ADocPackPublic.pdf

The papers for the September meeting will also include a summary of the events that have been undertaken and planned before the November HWB meeting. The papers have not yet been published but will be available from 6th September on https://present.brighton-hove.gov.uk/ieListMeetings.aspx?CommitteeId=826



**Background and context**

Brighton and Hove Connected full information, including the city strategy can be found here

http://www.bhconnected.org.uk/

http://www.bhconnected.org.uk/sites/bhconnected/files/Introduction%20to%20SCS%20doc..pdf

Each key area has an aim – for health and wellbeing this is:

A place where there is a shared vision to improve health, care and wellbeing for everyone living and working in the city and for generations to come, by improving the conditions which influence our health, and by promoting healthy lifestyles, treating illnesses, providing care and support and reducing inequalities in health.

**Progress to date**

MyLife – full details can be found https://www.mylifebh.org.uk/

**Performance reporting**
The HWB and Health Overview & Scrutiny membership jointly review performance information in 1/4/y meetings. This ensures that there is adequate time for covering all social care data as the Terms of Reference for the HWB also cover the Adult Social Care Committee responsibilities. This also allows for Better Care Fund detail to be examined.

**Adult Social Care Direction of Travel** – the local account and direction of travel reports are due to come to the November 2017 HWB. This provides the context prior to the budget setting processes. This year the intention is for the joint commissioning intentions to be included rather than CCG and Council having separate reports.

*Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.*

## 1. Brighton and Hove Cancer Strategy 2017-2020

1.1. The Health and Wellbeing Board is asked to approve this Strategy.

1.2 This paper is for the Health & Wellbeing Board meeting on the 12th September 2017

1.3 Authors of the Paper and contact details;

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## 2. Summary

2.1 The joint Cancer Strategy (2017-2020) has been developed by Brighton and Hove's Cancer Action Group whose membership includes the CCG commissioners, service providers, Macmillan, patient representatives, data analysists, Cancer Research UK and the Council's public health specialists. (Full membership list is at Appendix 1 of the Cancer Strategy) . The strategy's vision is to improve outcomes for cancer patients in Brighton and Hove and improve the experience of those affected by cancer. The Strategy outlines actions to achieve high quality services based on individual needs and which have a clear focus on prevention, early diagnosis, high quality treatment, and support for those living with and beyond cancer.

2.2 It aims to be a living document, where the action table is further developed in light of local needs and priorities. Actions will be monitored and developed through the Brighton and Hove Cancer Action Group.

2.3 This strategy has been informed by the National Cancer Strategy[1], our local Joint Strategic Needs Assessment, local operating plans and strategies and recently published data.

2.4 The strategy is separated into six sections which are aligned to the six priority areas outlined in National Cancer Strategy, these are:

- Prevention
- Early Diagnosis
- Patient Experience
- Living with and Beyond Cancer
- Modernising Cancer Services
- Commissioning accountability and provision.

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## 3. Decisions, recommendations and any options

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3.1 That the Board is asked to approve the Cancer Strategy.

3.2 That the Board agrees to receive an update including an estimate of the strategy's predicted impact on clinical and financial outcomes, including a sensitivity analysis, at the March 2018 meeting.

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[1] Independent Cancer Taskforce Review; Achieving World Class Cancer Outcomes, A strategy for England 2015-2020
http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

## 4. Relevant information

4.1 The BHCC and CCG joint local strategy is informed by 'Achieving World Class Cancer Outcomes, A strategy for England 2015-2020 National Cancer Strategy' which provides a transformational framework for the prevention, diagnosis, treatment and care for people affected by cancer. The NHS Operational Planning and Contracting Guidance[2], the Five Year Forward View and Next Steps of the Five Year Forward View[3] all of which contain relevant recommendations, actions and targets.

4.2 The Cancer Action Group oversees the Strategy and its delivery. It has a membership drawn from a range of organisations and partners with terms of reference, a clear reporting line to the Brighton and Hove Planned Care and Cancer Board and through to the Health and Wellbeing Board. (see page 49).

4.3 The incidence and deaths from cancer is increasing nationally and locally as the population lives for longer. Cancer Research UK states that one in two people will develop cancer at some point in their lives.

4.4 Cancer is the most common cause of death in England, accounting for 27% of all deaths. It is also the most common cause of premature death, accounting for 42% of deaths in those aged under 75 years.[4]

4.5 The picture is similar in Brighton & Hove with cancer accounting for 28% of all deaths and 40% of deaths in those aged under 75. [5]

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[2] The 2017-2019 NHS Operational Planning and Contracting Guidance https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

[3] Five Year Forward View (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf and The Forward View into Action (2015) https://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf and Next Steps of the Five Year Forward View (2017) https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

[4] ONS Vital Statistics (2015 data) [Accessed 13.6.17] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/vitalstatisticspopulationandhealthreferencetables]

[5] Primary Care Mortality Database, NHS Digital (2015 data). http://content.digital.nhs.uk/pcmdatabase

4.6 Despite improvements in cancer survival and mortality in recent decades, outcomes in the UK are poor compared with the best in Europe. A report in the Lancet in 2015[6] analysing common cancer 5-year survival rates showed that the UK was lagging behind with rates in 2005-2009 similar to what other Western European countries had achieved ten years earlier.

4.7 In Brighton and Hove City, with a population of approximately 287,000 around 1150 people in the city are diagnosed with cancer each year; of these, over half are for the four most common cancers (210 female breast, 150 lung, 140 colorectal and 135 prostate). These cancers are also responsible for about half the premature deaths in the City (75 from lung cancer, 26 from breast cancer, 23 from colorectal cancer and 6 from prostate cancer).

4.8 Incidence and mortality from cancer is considerably higher amongst the more deprived groups, largely due to late presentation, resulting in later diagnosis and access to health services. The mortality gap between the poorest groups and the most affluent appears to be widening.

4.9 Tobacco smoking remains the most important avoidable cause of cancer in the UK, followed by diet, excess body weight; due to diet and inactivity, and alcohol consumption. Cancer Research UK estimate that 42% of cancers in the UK are preventable through lifestyle choices[7]. Exposure and conditions at work, sunlight and sunbeds, infections, radiation, not breastfeeding and hormone replacement therapy are also key risk factors. The importance of lifestyle choices can be seen when it is borne in mind that less than 5% of cancer is genetically linked.[8]

4.10 In terms of cancer screening the national screening programmes aim to detect cancer early when treatment is more likely to be effective. Cancer Research UK estimates that cervical screening saves 5,000 lives in England each year, while breast screening saves 1,300. Regular bowel cancer screening reduces the risk of dying from bowel cancer by 16%. In Brighton & Hove screening rates for all of the three national screening

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[6] Allemani C, Weir HK, Carreira H *et al* and the CONCORD Working Group. Global surveillance of cancer survival 1995–2009: analysis of individual data for 25,676,887 patients from 279 population-based registries in 67 countries (CONCORD-2). *Lancet* 2015; 385: 977–1010. http://dx.doi.org/10.1016/S0140-6736(14)62038-9

[7] Cancer Research UK. 2017 http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers

[8] Cancer Research UK. Are all Cancer Hereditary? [Accessed on 16.8.13] Available from http://cancerhelp.cancerresearchuk.org/about-cancer/cancer-questions/are-all-cancers-hereditary

programmes; breast, bowel & cervical cancer, are lower compared to the rates for both the South East and England.[9]

4.11 NHS England published new ratings in October 2016 providing a snapshot of how well different areas of the country were diagnosing and treating cancer and supporting patients. Table 1 shows the indicator ratings for Brighton and Hove CCG.

**Table 1: Brighton and Hove CCG Indicator Rating[10]**

| Rating | Brighton and Hove CCG - Indicator Rating | | | |
|---|---|---|---|---|
| | New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed | Of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral | Of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis. | "Overall, how would you rate your care?" (with a score from 0 to 10, where 10 is the best.) |
| **Brighton and Hove Overall rating (Requires Improvement)** | 47.3% | 82.1% | 68.9% | 8.5 |
| **Best performing CCG** | 61.0% | 94.9% | 74.5% | 9.0 |
| **Worst performing CCG** | **37.5%** | **55.8%** | **64.7%** | **8.3** |

[9] PHE Screening update October 2015
https://cpdscreening.phe.org.uk/getdata.php?id=14456

The Independent UK Panel on Breast Cancer Screening. The Benefits and Harms of Breast Cancer Screening: An Independent Review. A report jointly commissioned by Cancer Research UK and the Department of Health (England). October 2012.
Cochrane Database of Systematic Reviews, 2006. Screening for colorectal cancer using the faecal occult blood test: an update.
Public Health England: Fingertips Cancer Services Profile [Accessed 5.7.17]
https://fingertips.phe.org.uk/profile/cancerservices
8 https://www.nhs.uk/service-search/scorecard/results/1173

| | | | | |
|---|---|---|---|---|
| **Eastbourne, Hailsham and Seaford rating (Inadequate)** | **44.2%** | **75.3%** | **68.8%** | **8.8** |
| **High Weald and Lewes Havens (Requires Improvement)** | **51.1%** | **77.5%** | **69.9%** | **8.7** |
| **Coastal West Sussex (Requires Improvement)** | **51.7%** | **85.2%** | **69.7%** | **8.6** |
| **Crawley (Requires Improvement** | **55%** | **82.6%** | **66.7%** | **8.7** |
| **Horsham and Mid Sussex (Good)** | **49.4%** | **80.6%** | **71.5%** | **8.7** |

4.12 Brighton and Sussex University Hospital (BSUH) continued to be challenged in meeting the 62 day urgent GP referral to treatment standard in 2016/17. This has in part been due to increase in activity and pressures within the system in diagnostics and bed pressures. There has been a focus locally and nationally on achieving the 62 day standard and work in sustaining cancer performance. Estimated increases in activity are set out on page 14 of the Strategy in response to implementing NG12 Guidance. NHS England are working with Cancer Alliances to drive clinical leadership and change in local areas, supported by transformational funding, targeted investment in addition to local funding arrangements.

4.13 The experience of cancer patients in England is generally very positive. Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.7. On nearly half of the questions in the survey, over 80% of respondents gave positive responses. Brighton, Sussex and University Hospital (BSUH) had an average rating of 8.6. 86% of people rate their overall care as excellent or very good. The England average is 89%. 68% reported that hospital and community staff always worked well together (compared with the England average of 63.5%).

Brighton and Hove can make improvements in two areas;

- 77% said that they found it easy to contact their Clinical Nurse Specialist (CNS) (compared to 87% nationally)
- 36% said that they were given understandable information about whether radiotherapy was working (compared to 60% nationally).

4.14 This Strategy aims to address the various opportunities to improve patient outcomes;

- Prevention, by improving health and wellbeing, addressing risk factors and improving screening uptake.

- Early diagnosis, by shifting from detection due to symptoms, to detection as a result of screening using tools such as practice profiles, the cancer decision toolkit, communication and engagement with the public and utilising NHS Health Checks and faster investigation and increased diagnostic capacity.

- Prompt high quality treatment, by addressing patient and system initiated delays. Delivering integrated end to end seamless 62 day pathways; improved patient outcomes and experience using a very efficient model of care.

- Survivorship, - with improvements in early detection and rapid advances in treatment, we should expect even larger numbers of people living with and beyond cancer, and greater numbers of people acting as carers for people with cancer. This requires a shift away from the medical model of care to one that sees the patient and the public being empowered to take up ownership of their care.

4.15 Around 1,100 people are diagnosed with cancer each year in Brighton and Hove. The nature of the tumour and the stage at which it is diagnosed will directly impact on life expectancy. Treatment for cancers at an earlier stage generally have better outcomes for the patient and are less costly to the health care system.

4.15 Financial impacts will need to be considered in the light of different commissioning responsibilities:[11]

- Prevention: Approximately 50% Public Health England, 25% Local Authority Public Health and 25% CCGs
- Screening: Public Health England
- Diagnostics: Approximately 90% CCGs and 10% NHSE - Specialised Commissioning.
- Treatment: (Radiotherapy, Chemotherapy, Specialist Surgery, and Non-Specialist Surgery): NHSE– Specialised Commissioning have 100% of the responsibility for Radiotherapy, Chemotherapy and Specialist Surgery. CCGs hold 100% of the responsibility for Non-Specialist Surgery.
- Follow up/Surveillance: Approximately 95% CCGs and 5% NHSE
- Rehabilitation & Survivorship, and Palliative Care/End of life Care – approximately 80% CCGs and 20% Local Authorities

4.16 The National Cancer Strategy[12] highlights that the cost of cancer in the NHS is likely to grow rapidly due to increasing incidence, healthcare inflation and new technology Through investing in early diagnosis, cost efficiencies and cost savings can be made. Cost increases have already been taken into consideration in the Five Year Forward View baseline assumptions, which for cancer, are predicted to grow by around 9% per annum over the next five years, in the absence of any efficiency savings.

- In 2017/18 following NICE guidance (NG12)[13] Brighton and Hove CCG has invested an additional 1.4% in consultant led first outpatient appointments (n=1066) and 1.6% in consultant led follow up outpatient appointments (n=1,132) on top of a 3.8% growth increase in in acute contract.

[11] https://www.macmillan.org.uk/about-us/working-with-us/health-social-care-commissioners/strategic-commissioning/england.html#253898
https://www.macmillan.org.uk/about-us/images-long-descriptions/commissioning-pathways-infographic.htm

[12] Achieving Word Class Outcomes for Cancer 2015-2020 A Strategy for England; Independent Cancer Taskforce Review (2015)
http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

[13] https://www.nice.org.uk/guidance/ng12

- Efficiencies and cost savings have been identified throughout the cancer pathway within the National Cancer Strategy which includes stratified pathways and the introduction of direct access tests. The National Strategy recognised that further work is required to finalise the estimated costs and savings.

- Monies will be available through the Surrey and Sussex Cancer Alliance to transform cancer care including early diagnosis, treatment and living with and beyond cancer. £2.9 million has been made available to the south region to support 62 day recovery plans.

4.17 To illustrate the potential outcomes from investing in prevention and earlier detection examples of national clinical and financial impacts are given below.

- Four out of ten cancers could be prevented by individuals adopting healthier lifestyles. The most important of which is smoking which leads to one in six of all the deaths of people over 35 years of age including over a quarter of deaths caused by a range of cancers. Lung cancer risk is around 26 times higher in men who smoke 15-24 cigarettes per day, compared with never-smokers. The estimated incidence rate of lung cancer in England is 77 cases per 100,000 population of which over 80% are caused by smoking.

- The estimated return on investment of smoking cessation services is £1.77 for every £1 spent. [14]

- Jo's Cervical Cancer Trust [15] has calculated that increasing cervical screening coverage from current [16] England levels of 72.8% to 84% could save the NHS £10 million a year. The average cost to the NHS per person diagnosed with stage 2 or later cervical cancer is £19,261, whilst for those at stage 1a, the cost to the NHS is around £1,379 per person.

[14] Masters et al J Epidemiology Community Health 2017; 71:827-834
[15] https://www.jostrust.org.uk/get-involved/behind-the-screen
[16] 2015/16 figures updated from Jo's Trust report

4.18 A report by Cancer Research UK *Saving lives, averting costs, An analysis of the financial implications of achieving earlier diagnosis of colorectal, lung and ovarian cancer.* published in September 2014, provides an example of modelling of cost and stage for 4 cancers that are equal to 21% of all cancers nationally; [17]

4.19 As table 2 from the report shows the estimated cost of treating cancer at an early stage (stages 1 and 2) is generally less expensive than treatment for more advanced disease:

Table 2: Cost associated with cancer stage

| **Stage** | **Colon cancer** | **Rectal cancer** | **Lung cancer** | **Ovarian cancer** |
|---|---|---|---|---|
| 1 | £3,747.63 | £4,803.52 | £16,409.07 | £6,831.21 |
| 2 | £9,810.70 | £8,834.25 | £18,694.95 | £18,840.35 |
| 3 | £13,974.87 | £12,792.04 | £20,984.13 | £23,482.19 |
| 4 | £12,518.58 | £11,815.28 | £13,077.65 | £15,080.66 |
| | | | | |
| | | | | |
| Local incidence[18] per100,000 | colorectal 67.98 (England 70.43); | | lung 82.22 (England 77.6) | ovarian 26.6 (England 24.0) |

4.20 Table 3 shows the estimated number of additional patients diagnosed with early stage cancer and the resulting additional savings and costs that would be achieved if the overall performance of all CCGs were equivalent to the best performing CCG's diagnostic profile for the four cancers considered. In total over 11,000 people would have their cancer diagnosed at an earlier stage which result in savings of over £44 million pounds.

[17] Costings based on NICE guidelines, NHS reference costs and Healthcare Resource Group (HRG)

[18] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/?location-name-1=NHS Brighton & Hove CCG&location-1=09D

Table 3: summary of patient impact and NHS cost implications of achieving the best in England

| Cancer Type | Additional patients diagnosed with early stage cancer | Additional costs |
|---|---|---|
| Colon cancer | 4,516 | -£24,435,267 |
| Rectal cancer | 1,707 | -£9,624,907 |
| Non-small cell lung cancer | 3,468 | £6,477,471 |
| Ovarian cancer | 1,406 | -£16,673,157 |
| **Total** | **11,097** | **-£44,255,861** |

4.21 To put these savings into context, the overall savings for the four cancers amount to 5 % of the overall treatment budget for colon, rectal, non-small cell lung and ovarian cancer. This is a significant saving given the pressures facing health services. Without action to reduce late diagnosis, treatment costs for these four cancers were predicted to rise by approximately £165 million. Yet, if the number of cancers diagnosed at a late stage were halved, then this cost increase would reduce to £111 million, benefiting over 27,000 patients.

4.22 Cancer Research UK outlined that if the findings for these four cancers were replicated for all cancers, then savings in treatment costs of approximately £210 million would be realised, resulting in over 50,000 people being diagnosed with earlier stage cancer.

## 5. Important considerations and implications

Legal:

5.1 There are no legal implications arising from this report.

Lawyer consulted: Elizabeth Culbert Date: 21/08/17

Finance:

5.2 The Public Health funded contract to 'Increase uptake of cancer screening programme' within Brighton and Hove Cancer Strategy is funded equally by the main Public Health Grant and the Brighton and Hove CCG as part of awareness and prevention activity. The total value of the contract is £0.270m over the 3 years (£0.1m for 17-18 and 18-19 with a reduction to £0.071m in 19-20 due to part year effect of the CCG 3 year funding). The contract outlined in this report is within the allocated budget.

Finance Officer consulted: Sophie Warburton Date: 31/08/2017

Equalities:

5.3 Age: Incidence increases with age for most cancers, yet older people in Brighton and Hove are not aware of their increased risk and have lower awareness of cancer symptoms than younger groups. There is evidence that older people's cancers are investigated and treated less intensively. [19]

5.4 Gender: Cancer incidence and mortality is higher in men than women but, more women than men are living with or beyond a diagnosis of cancer. Men have a lower awareness of the signs and symptoms of cancer.

5.5 Socio-economic deprivation: Incidence and mortality from cancer is considerably higher in the more deprived groups, largely due to lifestyle factors, especially higher smoking rates.

5.6 Brighton & Hove is a local authority with particularly high levels of smoking: 20.9% of the adult population smoke, compared to the England average of 16.9%. Amongst routine and manual workers, this rises to 34.2% of the adult population compared to the England average of 26.5%.[20]

[19] The Age Old Excuse: The under treatment of older cancer patients; Macmillan Cancer Support Report. [Accessed 13.6.17] http://www.macmillan.org.uk/documents/getinvolved/campaigns/ageoldexcuse/ageoldexcusereport-macmillancancersupport.pdf

[20] Public Health England: Fingertips Cancer Services Profile [Accessed 5.7.17] https://fingertips.phe.org.uk/profile/cancerservices

5.7 There is evidence of poorer uptake of bowel and cervical cancer screening in GP practices with more deprived populations. This link with deprivation is not seen in breast screening. Screening uptake rates tend to be highest in the West locality which has fewer practices with more deprived populations.[21]

5.8 Ethnicity: Women from BME groups (including White Other) are more likely to present with more advanced breast cancers and have poorer survival than White British women. Locally non-white residents were more likely to perceive barriers to help-seeking. [22]

5.9 Sexuality: Differences in health-related behaviours among lesbian, gay, bisexual and transgender (LGBT) people may lead to differences in cancer incidence. Perceptions of risk and healthcare seeking behaviour may also vary. In 2012, a survey of 152 people from the LGBT community was carried out to investigate health and inclusion. In terms of cancer screening, a high percentage of LBQ women were not having smears at regular intervals although this can be said to be true of the Brighton & Hove screening population generally. Some individuals had been wrongly informed that they were not at risk because of their sexuality. [23]

5.10 Disability: There is limited national information on variations in cancer incidence, treatment and outcomes for people with a disability. People with learning disabilities appear to have a similar age standardised incidence rate for all cancers combined but incidence by tumour site may be different. There is some evidence for increased cancer incidence associated with some mental illnesses, which is associated with increased cancer mortality.35 A recent report found that eligible females without learning disabilities were more likely to receive breast cancer screening than eligible patients with learning disabilities.[24]

[21] National Cancer Intelligence Network. Evidence to March 2010 on cancer inequalities in England. June 2010. [Accessed 30.08.13] Available from http://www.ncin.org.uk/view?rid=169
[22] Cancer Inequalities in the South East Region: The Burden of Cancer http://www.sepho.org.uk/Download/Public/10398/1/cancerIneq1_051006_FINAL.pdf

Lake Market Research. Cancer Awareness and Early Diagnosis Initiative CAM Final Results. NHS Brighton and Hove: April 2010.
[23] LGBT Health and Inclusion Project: Lesbian, Bisexual and Queer Women's Health Survey – Report (2012).
[24] Public Health England: Learning Disabilities Health and Care: The New Information Source, presented at the South East Public Health Information Group, June 2017

Sustainability:

5.11 The demand on services will increase as the population ages.
Prevention screening and service provision needs to be considered the STP.
Reducing smoking will have an impact on environmental pollution .

5.12 Health, social care, children's services and public health:

There are and will need to be appropriate commissioning of services to prevent, screen, diagnose, treat and support people living beyond cancer across the age range and to address specific inequalities.

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## 6. Supporting documents and information

Appendix 1 The Cancer Strategy
Appendix 2 Updated JSNA on cancer and cancer screening.

Brighton & Hove City Council

NHS
Brighton and Hove
Clinical Commissioning Group

# Brighton and Hove

# Cancer Strategy

# 2017 – 2020

# Contents

# FORWARD

This Cancer Strategy (2017-2020) has been developed by our local Cancer Action Group. The group's vision is to improve outcomes for cancer patients in Brighton and Hove and improve the experience of those affected by cancer. We will do this through establishing high quality services that are focussed on individual needs which have a clear focus on prevention, early diagnosis, high quality treatment and support for those living with and beyond cancer. We also need to ensure that we have a range of services to meet the needs of people affected by cancer which requires modernising services across the system through rapid access to diagnosis, engaged workforce and supporting clinical research.

We recognise that to achieve this we have to work in partnership with people affected by cancer to develop services. This strategy represents the first major step towards fulfilling our goal of bringing together all partners in a commitment to transform services and sets out the actions we will jointly take over the next two to three years.

The NHS and the local authority face several pressures over the next few years with increased demand on services and limited resource. Demand for cancer services is rising three times faster than other conditions for the NHS and services are struggling to meet operational standards under the current pressures. Cancer is a local and national priority and we will work in partnership to develop models of care that meet the needs of Brighton and Hove. We will work as part of a wider system through the Sustainability and Transformation Partnership and the Surrey and Sussex Cancer Alliance.

This strategy has been informed by the National Cancer Strategy, our local Joint Strategic Needs Assessment and recently published data and has been developed by the Cancer Action Group, members organisations of the CAG can be found in appendix 1. The strategy is a powerful indication of our shared commitment to preventing cancer and to ensuring that people affected by cancer are able to access the right intervention, in the right place, at the right time and with the right outcome.

David Supple
Clinical Lead

Peter Wilkinson
Director of Public Health

# Section 1 – Introduction

National Policy Context | Brighton and Hove Context | Our Vision and Aims | Principles

Brighton and Hove is committed to improving outcomes for people affected by cancer. Significant improvements have been made in treatment and survival in cancer, but there now needs a step-change in the way cancer service provision is delivered for people living with the disease and the role the patient plays within that. This requires coordination and integration between key organisations, particularly Public Health England, Brighton and Hove Local Authority, Brighton and Hove Clinical Commissioning Group (CCG) and NHS England to ensure the entire patient pathway from prevention to end of life is connected.



This strategy aims to address the various opportunities to improve patient outcomes in the pathway outlined by the Independent Cancer Taskforce (2015)[1].

A. **Prevention,** by improving health and wellbeing, addressing risk factors and improving screening uptake.

B. **Early diagnosis,** by shifting from detection due to symptoms, to detection as a result of screening using tools such as practice profiles, the cancer decision toolkit, communication and engagement with the public and utilising NHS Health Checks and faster investigation and increased diagnostic capacity.

C. **Prompt high quality treatment,** by addressing patient and system initiated delays. Delivering integrated end to end seamless 62 day pathways; improved patient outcomes and experience using a very efficient model of care.

[1] Achieving Word Class Outcomes for Cancer 2015-2020 A Strategy for England; Independent Cancer Taskforce Review (2015) http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

D. **Survivorship,** - with improvements in early detection and rapid advances in treatment, we should expect even larger numbers of people living with and beyond cancer, and greater numbers of people acting as carers for people with cancer. This requires a shift away from the medical model of care to one that sees the patient and the public being empowered to take up ownership of their care.

E. **Patient Experience** is improved through early detection and access to services, through to treatment and recovery. Outcomes from national and local surveys will be acted upon to drive forward improvements.

In 2016 Brighton and Hove became part of three larger footprints in order to develop and commission new models of care. These are:

A. Sussex and East Surrey Sustainability and Transformation Partnership
B. South Central Sussex and East Surrey Alliance Place Based Plan (CSESA)
C. Surrey and Sussex Cancer Alliance.

The aims of these plans is to build on local plans over a wider geographical area and to look at what programmes could be improved if we worked with neighbouring CCGs, local authorities and NHS providers to deliver them together. It provides an opportunity for a more joined-up approach between public health teams across the region such as cancer screening programmes. Cancer is detailed as an area of focus which can deliver the greatest public health and wellbeing improvements, based on current deaths, years of life lost, healthcare costs and health inequalities across the Sussex and East Surrey footprint population.



CSESA proposes to further develop collaborative clusters of General Practice serving populations of approximately 50k, and 20 ‘care hubs’ known as Multi-Specialty Community Providers (MCP) across the CSESA footprint by 2020. This will integrate community health, mental health, social care and third sector support in order to improve the care provided to our local population, improve health outcomes and drive a greater level of efficiency across the whole system.

The Cancer Alliance will focus on providing improvement in early diagnosis, the recovery package and the development of stratified pathways through executive leadership which links into the plans outlined above.

# National Policy Context

**Achieving Word Class Outcomes for Cancer 2015-2020; A Strategy for England[1] Independent Cancer Taskforce Review**

This Strategy provides a transformational framework for the diagnosis, treatment and care for people affected by cancer and works towards delivering a gold standard service. This builds on the Cancer Reform Strategy (2008) and Improving Outcomes: A strategy for Cancer[2].

The strategy sets out a vision for what cancer patients should expect from the health service which are:

A. Effective prevention though lifestyle changes so that people reduce their risk of getting cancer
B. Prompt and accurate diagnosis; informed choice and convenient care
C. Access to the best effective treatments with minimal side effects
D. Always knowing what is going on and why
E. Holistic support; and the best possible quality of life, including at the end of life
F. Patients are treated as individuals, with compassion, dignity and respect throughout their care.



In order to achieve this, six strategic priorities have been detailed with over 100 recommendations for NHS England (NHSE). This includes Prevention; Early Diagnosis; Patient Experience; Living with and beyond Cancer; Modernising cancer services; Commissioning, accountability and provision. It is anticipated, that though the work being carried out through early diagnosis we will significantly improve one-year survival rates to 75% by 2020 for all cancers (Brighton and Hove CCG currently have a 69% one year survivorship rate).

**The 2017-2019 NHS Operational Planning and Contracting Guidance[3]**

The 2017-2019 NHS Operational Planning and Contracting Guidance states that by 2020 we will need to be:

A. significantly improving one-year survival to achieve 75% by 2020 for all cancers combined (up from 69% currently); and
B. 95% of patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP, and 50% within 14 days.

[2] Cancer Reform Strategy (2008) http://www.nhs.uk/NHSEngland/NSF/Documents/Cancer%20Reform%20 Strategy.pdf Improving Outcomes: A Strategy for Cancer (2011) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf
[3] The 2017-2019 NHS Operational Planning and Contracting Guidance https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

The key deliverables include:

A. Working through Cancer Alliances and the National Cancer Vanguard to implement the national cancer strategy.
B. Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards.
C. Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
D. Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.
E. Ensure all elements of the Recovery Package are commissioned, including ensuring that:
    - all patients have a holistic needs assessment and care plan at the point of diagnosis
    - a treatment summary is sent to the patient's GP at the end of treatment; and
    - a cancer care review is completed by the GP within six months of a cancer diagnosis.

**Five Year Forward View[4]**

The Five Year Forward View sets out a clear direction for the NHS, highlighting why change is needed and what it will look like. It states action needs to happen in three areas: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. The change outlined not only requires changes in the NHS but the development of partnerships with local communities, local authorities and employers to deliver improvements. The Forward View into Action[5] includes prevention and co-creating new models of care to improve outcomes. Key points to note include:

A. Increasingly we need to manage systems – networks of care – not just organisations.
B. Out-of-hospital care needs to become a much larger part of what the NHS does.
C. Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them.
D. We should learn much faster from the best examples, not just from within the UK but internationally.
E. And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

The Five Year Forward View recognises that the NHS has dramatically improved patient outcomes over the past fifteen years. Cancer survival is at its highest ever; outcomes are better; waits are shorter; patient satisfaction much higher across the country which is due to the commitment of

[4] Five Year Forward View (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[5] The Forward View into Action (2015) https://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf

staff and funding. It also recognises quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. It also highlights the challenges in cancer as patient needs change; there are new treatment options and increasing pressure on services.

**Next Steps of the NHS Five Year Forward View**[6]

The next steps highlights the process that has been carried out a year on across the health system and what still needs to be done. It highlights that identifying cancer earlier is critical to saving more lives which requires the need to speed up and improve diagnosis, increase current capacity and open new Rapid Diagnostic and Assessment Centres which is a key focus of the Cancer Alliances. The document details the complex and challenging times for the NHS with pressures being greater than they have ever been. The NHS in 2017 confronts four paradoxes.

A. We are living longer but associated with this and other factors we are using the NHS more. Life expectancy has been rising by five hours a day, but the need for modern NHS care continues to grow.
B. The quality of NHS care is demonstrably improving, but we're becoming far more transparent about care gaps and mistakes.
C. Staff numbers are up, but staff are under greater pressure.
D. The public are highly satisfied with the NHS, but concerned for its future. Perhaps surprisingly, newly published independent data spanning three decades shows that public satisfaction with the NHS is higher than in all but three of the past 30 years.



Key improvements for cancer in 2017/18 and 2018/19 include:

A. Expanded screening to improve prevention and early detection of cancer which will introduce a new bowel cancer screening test for over 4 million people from April 2018 and the introduction of primary HPV testing for cervical screening from April 2019.
B. Expand diagnostic capacity so that England is meeting all 8 of the cancer waiting standards, compared to seven out of eight today. We will focus specifically on the cancer 62-day from referral to treatment standard ahead of the introduction of the new standard to give patients a definitive diagnosis within 28 days by 2020.
C. NHSE will implement the largest radiotherapy upgrade programme in 15 years by October 2018, patients will have access to sustainable high quality, modern radiotherapy treatments wherever they live. BSUH has received new equipment as part of this work.

NHSE will support this through:

A. Ensuring there is additional resource allocated to cancer.

[6] Next Steps of the Five Year Forward View (2017) https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

B. Expanding the cancer workforce: HEE to have trained 160 non-medical endoscopists by 2018, alongside 35 more places for ST1 clinical radiology training.
C. Clear accountability and delivery chain. Performance goals for CCGs and cancer providers, matched by unprecedented transparency using the new cancer dashboard.

## Brighton and Hove Context

The following headlines (Table 1) for Brighton and Hove[7] have been taken from Local Cancer Intelligence which is a collaboration between Macmillan Cancer Support and Public Health England's National Cancer Intelligence Network (NCIN), combining the best data and insights from NCIN, Macmillan and other sources to help understand the local burden of cancer.

**Table 1: Local Cancer Intelligence**

| Metric | Brighton and Hove |
|---|---|
| **Prevalence** | As of the end of 2010, around 6,500 people were living up to 20 years after a cancer diagnosis. This could rise to an estimated 12,700 by 2030 |
| **Incidence** | There are 629 new cancer diagnoses per 100,000 people each year, this is similar to the England rate (611 per 100,000 people). |
| **Mortality** | There are 295 cancer deaths per 100,000 people each year, this is similar to the England rate (284 per 100,000 people). |
| **One year survival** | One-year cancer survival is 67%, this is poorer than the England rate of 69%. |
| **Five year survival** | Five-year cancer survival is 49% in Surrey and Sussex, the England rate is 49% |
| **Patient Experience** | 86% of people rate their overall care as excellent or very good. The England average is 89%. People rate each aspect of their care differently: e.g. 68% reported that hospital and community staff always worked well together (compared with the England average of 63.5%). |
| **Route to & from diagnosis** | The Routes to and from Diagnosis and associated outcomes for select cancers are presented in detailed pages for breast, prostate, and lung cancers and brain and central nervous system (CNS) tumours accessed via http://lci.cancertoolkit.co.uk/HeadLines |

[7] The is based on the CCG's registered population.

## Cancer a clinical priority

Cancer is the main cause of death for all ages and for those under 75 years in the City. In 2015 it was the cause of nearly a third of all deaths (27%) and 40% of all premature deaths locally. Lung, bowel, breast and prostate cancer account for nearly half of all cancer diagnoses[8]. These rates are similar to those for England with cancer being the main cause of all deaths in the country accounting for 27% of all deaths and 42% of premature deaths (in under 75's in 2015). In terms of screening Brighton and Hove is statistically significantly below the national average for all screening measures according to 2016 Public Health England data[9]. Screening rates are typically lower in areas with higher percentage BME populations and in more deprived areas. Brighton & Hove lesbian, gay, bisexual and transgender (LGBT) communities have higher rates of cervical screening than the general population due to community health improvement programmes.

Emergency Presentation for cancer in Brighton and Hove is lower than the national average with 79 /100,000 emergency presentations in comparison to 89/100,000. Brighton and Hove has a high number of two week wait referrals for suspected cancer (3366/100,000) in comparison to the England average (2975/100,000) with a conversion rate[10] of 6.1% (England 7.8%)[8]. Two week wait referrals have continued to increase year on year with demographic growth putting more pressure on the system.

In Brighton and Hove City, with a population of approximately 287,000, around 1150 people in the city are diagnosed with cancer each year; of these, over half are for the four most common cancers (210 female breast, 150 lung, 140 colorectal and 135 prostate). These cancers are also responsible for about half the premature deaths in the City (75 from lung cancer, 26 from breast cancer, 23 from colorectal cancer and 6 from prostate cancer). NHS England published new ratings in October 2016 providing a snapshot of how well different areas of the country were diagnosing and treating cancer and supporting patients. This was based on data published over the previous two years and the CCG improvement and assessment framework provides an initial baseline rating for six clinical priority areas which includes cancer. Table 2 shows the indictor ratings for Brighton and Hove CCG.



[8] ONS mortality data 2015– not available on-line
[9] Fingertips Practice Profiles https://fingertips.phe.org.uk/
[10] Conversion rate: the proportion of urgent referrals for suspected cancer by general practitioners that result in a diagnosis of cancer. This is the positive predictive value for cancer among the patients selected for urgent referral

**Table 2: Brighton and Hove CCG Indicator Rating[11]**

| Rating | Brighton and Hove CCG - Indicator Rating | | | |
|---|---|---|---|---|
| **Needs Improvement** | New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed | Of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral | Of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis. | "Overall, how would you rate your care?" (with a score from 0 to 10, where 10 is the best.) |
| **Brighton and Hove Overall rating** | 47.3% | 82.1% | 68.9% | 8.5 |
| **Best performing CCG** | 61.0% | 94.9% | 74.5% | 9.0 |

Incidence and mortality from cancer is considerably higher amongst the more deprived groups, largely due to late presentation, resulting in later diagnosis and access to health services. The mortality gap between the poorest groups and the most affluent appears to be widening[12].

Despite improvements in cancer treatments, and mortality in recent decades, outcomes in the UK are poor compared to the best in Europe[13] (figure 1). The survival rate amongst the under 75's in the city is lower than the national rate[14]. At a national level, the mortality rate from cancer has been steadily decreasing, but this is not the case in Brighton and Hove, where the decline has been very small.



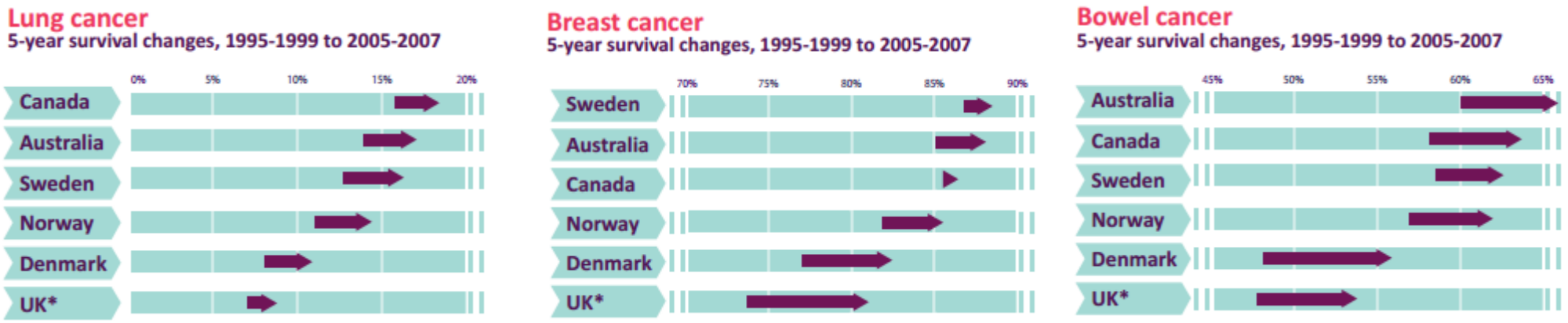
[11] https://www.nhs.uk/service-search/scorecard/results/1173

[12] Public Health Annual Report Brighton and Hove 2015/16 https://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove

[13] Is England closing the international gap in cancer survival? British Journal of Cancer (2015) https://www.nature.com/bjc/journal/v113/n5/full/bjc2015265a.html and http://scienceblog.cancerresearchuk.org/2015/08/05/cancer-survival-in-england-is-improving-but-still-lagging-behind-similar-countries/

[14] http://www.bhconnected.org.uk/sites/bhconnected/files/jsna/jsna-7.5.8-Cancer.pdf and https://present.brighton-hove.gov.uk/Published/C00000826/M00005746/AI00049010/$20151204150751_008319_0034662_AppendixoneJHWS.docA.ps.pdf

**Figure 1: 5-year survival changes for Lung, Breast and Bowel.[15]**




Using a new index of cancer survival, Brighton and Hove has poorer survival than England, although it is gradually improving. The age standardised incidence rate for all cancers in Brighton and Hove is higher than the national average and whilst the national rate has remained fairly static since 2009, Brighton and Hove has seen an increase. The most common cancer in females is breast cancer and in males prostate cancer[16]; the second and third most common cancers in both females and males are lung and colorectal cancer which is the same as England[17]

Brighton and Sussex University Hospital (BSUH) continues to be challenged in meeting the 62 day urgent GP referral to treatment and has seen a decline recently in other cancer standards as demonstrated below. This has in part been due to increase in activity and pressures within the system in diagnostics and bed pressures. Table 3 outlines the current performance of BSUH.



[15] Achieving Word Class Outcomes for Cancer 2015-2020 A Strategy for England; Independent Cancer Taskforce Review (2015) http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

[16] However the incidence of prostate cancer is linked to identification via Prostate Specific Antigen (PSA) testing.

[17] ONS Cancer Registration Statistics, England, 2011. 26 June 2013. [Accessed 16.8.13] Available from http://www.ons.gov.uk/ons/dcp171778_315795.pdf

**Table 3: Brighton and Sussex University Hospital performance against Cancer Waiting Time Standards and Constitutional Standards**

| Metric | Target | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|---|
| Cancer: 2 week GP referral to 1st outpatient appointment | 93% | 92.43% | 93.61% | 91.29% | 93.50% |
| Cancer: 31 day diagnosis to treatment from all cancers | 96% | 97.61% | 97.68% | 96.73% | 98.19% |
| Cancer: 62 day urgent GP referral to treatment. | 85% | 86.08% | 80.83% | 77.2% | 76.40% |
| Patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT). Incomplete pathways | 92% | 92.69% | 81.14% | 80.10% | 82.1% |

| Metric | Target | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer: 2 week GP referral to 1st outpatient appointment | 93% | 88.65% | 93.85% | 95.11% | 94.75% | 94.08% | 94.47% | 95.12% | 94.10% | 93.93% | 90.68% | 93.25% | 93..41% |
| Cancer: 31 day diagnosis to treatment from all cancers | 96% | 100.00% | 97.32% | 99.14% | 98.41% | 98.57% | 98.17% | 98.59% | 97.27% | 97.18% | 97.94% | 97.08% | 98.31% |
| Cancer: 62 day urgent GP referral to treatment. | 85% | 78.1% | 77.2% | 81.1% | 74.5% | 74.7% | 85.9% | 77.9% | 76.5% | 66.7% | 77.8% | 68.5% | 76.5% |
| Monthly Conversion rate | | **6.9%** | **6.6%** | **6.0%** | **8.4%** | **6.9%** | **6.7%** | **7.0%** | **6.9%** | **6.4%** | **8.8%** | **7.8%** | **8.7%** |



The Brighton & Hove Health & Wellbeing Board is a partnership group[18] to improve the health & wellbeing of local people. It produces a local Joint Health & Wellbeing Strategy, stating how the health & wellbeing of the local population will be improved. The most recent was produced in 2015[19] .It contains the target of 'Increase the uptake of health checks and cancer screening'.

NHS England, Public Health England and NHS RightCare commissioning for value pack 2016 identified cancer as one of the priority areas which will offer the best opportunities to improve healthcare for populations and improve the value that populations receive from investment in their local health system. RightCare (2016) states that across breast ,lower gastrointestinal and lung pathways Brighton and Hove could improve on screening for bowel and breast cancers and on one year survival rates in comparison to CCG's who have a similar demographic. Breast and lower gastrointestinal cancer detection at an early stage is recognised as requiring improvement.

[18] Brighton and Hove Health and Wellbeing Board: https://present.brighton-hove.gov.uk/mgCommitteeDetails.aspx?ID=826
[19] Brighton & Hove Joint Health & Wellbeing Strategy 2015 https://present.brighton-hove.gov.uk/Published/C00000826/M00005746/AI00049010/$20151204150751_008319_0034662_AppendixoneJHWS.docA.ps.pdf

**Brighton and Hove CCG have identified the following priority areas for action**

- Preventing people dying prematurely by improving early identification of symptoms in primary care
- Enhancing quality of life for people by improving outcomes and delivery of the national cancer survivorship programme
- To ensure treatment is commenced without delay by delivering the 62 day referral to treatment national standard

Brighton and Hove CCG will ensure that there is equitable access for services with particular focus on vulnerable groups. The CCGs will work closely with Providers, Local Authority, Public Health England and the South East Cancer Clinical Network (SECN) to ensure best practice is implemented wherever possible.

**NICE Guidance 12 (NG12); Suspected Cancer referral and Recognition**

The implementation of NG12 is the responsibility of local NHS commissioners and providers. There has been a significant piece of work carried out between Brighton and Sussex University Hospital (BSUH), Brighton and Hove CCG, Horsham and Mid Sussex CCG, Crawley CCG and High Weald Lewes and Havens CCG to collaboratively agree a joint implementation plan for BSUH. This has involved working with BSUH to map the current pathways and the new pathways following the implementation of NG12. This has included the Trusts ability to meet the reporting timeframes for direct access proposed by NICE. It has been agreed that in areas where reporting for direct access may be challenged, such as within 48 hours of being requested we will pilot and work towards this. We have also agreed to aspire to 'straight to test' with the further development of pathways. Monitoring of the impact on the patient journey will be part of the evaluation of the implementation and development of pathways.

It is estimated that the impact on BSUH following the implementation for NG12 in 2017/18 will be the following:

GP direct access referrals and 2WW referrals
27,139 (currently 19,900 2WW referrals an increase of 7,239)

| | 62 Day Patients | Discharged back to GP | On RTT Pathway |
|---|---|---|---|
| Total Impact = | 1,579.0 | 15,070.0 | 10,467.0 |
| Additional = | 236.5 | 4,645.0 | 3,227.0 |

It is anticipated that following the launch of NG12 and taking account of growth there will be increased demand on diagnostics by 7,239 per annum (including planned care). This will impact on the number of patients being brought forward on the 62 day pathway (RTT) and the number referred back to GP to be managed.

## Our Vision and Aims

In line with our vision, we have developed some key aims in Brighton and Hove which link with national and local plans. These aims span all parts of the cancer pathway, from prevention, through early intervention to treatment and living with and beyond cancer.

- We aim, through this strategy, to work as a whole system on improving the outcomes for cancer patients in Brighton and Hove.
- We aim to develop strong and clear leadership and accountability arrangements in meeting the needs of our local population through the Cancer Action Group.
- We aim to ensure joint commissioning decisions are based on high quality, accurate data and the effectiveness of services evaluated through application of robust performance indicators, outcome measures and quality indicators to assure people affected by cancer are getting the best possible care and outcomes.



## Principles

The Cancer Action Group has developed the following principles to improve outcomes for people affected by cancer; these will be the golden thread throughout this strategy and the actions we take: We will:

- Work together to improve public awareness and understanding of preventing cancer and cancer signs and symptoms
- Ensure there that the workforce embeds the ‘Make Every Contact Count’ approach on healthy lifestyle behaviours and signposting to services
- Share statistical data to ensure a shared understanding of the needs of our population.
- Develop a pathways approach to ensure that patients where cancer is suspected receive the right service at the right time.
- Ensure that people affected by cancer feel informed and feel their individual needs are met.
- Always promote self-help whenever possible.
- Actively listen to the voice of people affected by cancer in the shaping of our services.
- Use best practice and evidence informed advice, support and interventions whenever possible, with the best balance of services to respond to the needs of people affected by cancer.
- Ensure our commissioned services are of good quality and provide value-for-money.

# Section 2 – Prevention

Evidence for change | Current Position | Where do we want to get to? | What we will do

NHS England 5 year Forward View (October 2014) highlights the need for radical upgrade in prevention and public health as one of the key elements required to ensure the sustainability of the NHS. This is emphasised in the Independent Cancer Taskforce Review (2015).

This section covers how we can improve the health and wellbeing of the local population. This includes the:

- Aim to improve healthy lifestyle behaviours including reducing smoking and alcohol consumption and increasing physical activity and healthy eating.
- Aim to increase sun safety.
- Aim to provide a healthy environment.

## Evidence for change

An estimated 42% of cases of cancer in the UK are preventable through the adoption of healthier lifestyle choices.[20] Lifestyle factors such as smoking, diet, drinking alcohol & physical activity are key with smoking being the single largest cause of cancer accounting for 19% of all cases.

- **Smoking:** In Brighton & Hove the prevalence of smoking in adults is 21%, higher than the national figure of 17%[21]. On average there are 370 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 in 2015/16.
  Brighton & Hove has more young people smoking than any other local authority in the South East. According to the national *What about Youth* survey smoking prevalence is 14.9%, 5.9% higher than the average for the South East (9%) and 6.7% higher than the national average (8.2%).[22]

- **Alcohol:** 42% of adults in Brighton & Hove drink more than the UK recommended weekly amount of alcohol[23]. This compares to the average for England of 26%. Rates of alcohol-related A&E attendance and hospital admissions have increased in recent years, and in Brighton & Hove's Big Alcohol Debate, 36% of respondents were worried about the effect alcohol has on people in the city.

- **Healthy weight:** Although the local figure for obese children is below the national average, 13.3% in year 6, compared to 19% for England, by adulthood over half (52.4%) of the adult population in Brighton & Hove are classified as overweight or obese[24]. Although this figure is also less than that for England at 64.6% excess weight could be lost by adopting a healthier diet, increasing physical activity & drinking less alcohol.

- **Air pollution.** The Air Quality Action Plan targets improvement in Nitrogen Dioxide ($NO_2$) focussing on roadside residential areas especially Brighton City Centre, South Portslade and Rottingdean High Street. Although pollution levels have improved over recent years it is estimated that within Brighton & Hove City Council 200 deaths are brought forward each year by airborne pollution.

[20] Parkin DM, Boyd L, Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. Summary and conclusions(link is external). Br J Cancer 2011;105 (S2):S77-S81
[21] Brighton & Hove Health Profile. PHE. 2016. Data for 2015. http://fingertipsreports.phe.org.uk/health-profiles/2016/e06000043.pdf
[22] What about YOUth Survey. 2014. http://content.digital.nhs.uk/catalogue/PUB19244
[23] Fingertips. PHE. 2016. Data for 2011-14. http://fingertips.phe.org.uk/search/adults%20drinking%20over%2014#pat/6/ati/102/par/E12000008
[24] Health Profile 2016. PHE. Excess weight in adults data 2012-14. And % of obese children in yr 6 data 2014-15. http://fingertipsreports.phe.org.uk/health-profiles/2016/e06000043.pdf

- **Sun Safety.** Brighton & Hove has a higher rate of malignant melanoma's than England, 27.4 cases per 100,000 people compared to 23.3 for England[25]. Sun safety is taken seriously by the City and there are programmes & campaigns in place to help people stay safe in the sun.

## Current Position

Our over-arching aim is to act early to prevent cancer by advising & supporting people to make healthy lifestyle choices. We have a series of services and initiatives which we will build on in the city:

A. We have commissioned in partnership (Brighton and Hove CCG and Public Health) a cancer prevention and early awareness service to educate the public and health care professionals on preventing cancer, the signs and symptoms of cancer and to increase uptake of the NHS National Screening Programmes.
B. Other Brighton & Hove CCG and Brighton & Hove City Council Locally Commissioned Services such as the alcohol, smoking cessation & NHS health Checks LCS also reduce the incidence of cancer.
C. The Healthy Lifestyles team at Brighton and Hove City Council. This team includes the Health Trainers who use behaviour change techniques to support people to adopt healthier lifestyle behaviours including healthy diet, stopping smoking, increasing physical activity, drinking less alcohol, and accessing other support services in the city. The Health Trainers also provide advice on appropriate cancer screening to the people that they see. These interventions are delivered in both a clinical & community setting.
   The team also includes the Active for Life programme helping people to increase physical activity; this includes the healthy walks programme including walks for those living with and surviving breast cancer. The team also support a healthier food environment and have Community Health Improvement Nurses.
D. A new Alcohol Liaison Nurse has been appointed in the centre of the City to work out of GP surgeries to provide advice & support to people to drink less alcohol or give up altogether.
E. The Brighton and Hove Food Partnership and the charity Albion in the Community offer healthy lifestyle programmes that can help adults, children and families to establish a healthier weight. They offer a healthy lifestyle programme called Shape Up. A more specialist weight management clinic is also available for children, delivered by Sussex Community Foundation Trust.
F. The Healthy Choice programme supports food businesses to prepare, cook and serve meals in a healthier way. Participating food businesses can qualify for a Healthy Choice Award.
G. The Sugar Smart project is a joint initiative from the Council, Food Partnership and Jamie Oliver Food Foundation that looks at what we can all do at home, in schools and in shops, restaurants, cafes and takeaways to tackle high levels of sugar in food.



[25] Fingertips. PHE. 2010-12 data. https://fingertips.phe.org.uk/search/malignant%20melanoma#page/0/gid/1/pat/6/par/E12000008/ati/102/are/E06000043

H. City-wide tobacco control action plan aims to reduce smoking prevalence. Initiatives include promoting stop smoking services, tackling cheap and illegal tobacco, supporting smokers to quit, making stop smoking services accessible, reducing exposure to second hand smoke, enforcing smokefree and tobacco products regulations, and preventing the uptake of smoking in young people.
I. Sun safety campaign in schools and for the wider community.
J. Health promotion training programme in the city which trains a wide range of paid and voluntary workers across the sectors and offers skills and topic based courses on issues such as Understanding Health Improvement, Making Every Contact Count, Promoting Physical Activity, Facilitating Behaviour Change around Drugs and Alcohol. https://learning.brighton-hove.gov.uk/cpd/portal.asp
K. Access Fund for Sustainable Travel Team at Brighton & Hove City Council. Grant funded by the Department for Transport until end of March 2020, provides a project based approach to encourage active and sustainable travel around the city. The main objectives of the project are to promote active travel to employment, education and skills, and to increase walking and cycling.
L. The NHS Health Checks programme aims to highlight and reduce the risks of developing cardio vascular disease diabetes, stroke, kidney disease & dementia and also promoting the awareness of preventing cancer & spotting the signs & symptoms of cancer.
M. There are 20 Healthy Living Pharmacies in the city. Each has a Healthy Living Champion who offer advice and support to people on leading a healthy lifestyle. This forms part of the national Make Every Contact Count agenda.
N. The national immunisation programme for Human Papilloma Virus (HPV) vaccinates young females against this virus to reduce the risk of cervical cancer.
O. Specialist worker in public health focussing on improving the health of those in the workplace. This includes promoting the national NHS Health Checks programme and offering on-site wellbeing checks for staff delivered by the Health Trainers. This post also oversees implementation of the national Workplace Wellbeing Charter in businesses & schools.
P. Communication plan to deliver national and local health improvement campaigns. There is strong partnership work across organisations in the city to join up messages and campaigns to provide a wider coverage.



But we know there is still more that can be done:

A. To tackle the wider determinants of health to reduce health inequalities in the City to improve healthy behaviours & access to services in the most deprived areas of the City.
B. To further reduce the number of smokers within the City.
C. To work with GP practices that have a low invite and uptake rate for the NHS Health Checks programme to reduce variation in this programme across the City.
D. To increase screening rates of people with learning disabilities, mental health issues and the BME and LGBT community.
E. To embed the Make Every Contact Count scheme.



F. To increase the implementation of the national Workplace Wellbeing Charter across more businesses and organisations in the City.

## Where do we want to get to?

A. Commission well-evidenced primary prevention programmes focussed on the key risk factors linked to Brighton and Hove biggest diseases.
B. Ensure cancer prevention is included in obesity, alcohol and tobacco strategies.
C. Continue for cancer to be a focus in the Health and Wellbeing boards to influence local commissioning arrangements to ensure measures to prevent cancer and other diseases are embedded across all activities and support the reduction in health inequalities.
D. To continue to address risk factors and improve screening uptake (see Section 3 action 9 and 8).

## What we will do

Action 1:
We will continue to promote healthy lifestyles across the city.

Action 2:
We will update the JSNA for Brighton and Hove with regards to cancer to ensure that our commissioning plans are informed by the latest intelligence on prevalence, incidence and outcomes.

Action 3:
We will work with primary care to reduce variation in preventative services provided through Locally Commissioned Services & increase the uptake of heath improvement services particularly for those living in the more deprived areas.

Action 4:
We will continue to develop Healthy Living Pharmacies across the city.

Action 5:
We will skill up the workforce to provide brief advice and interventions in Making Every Contact Count.

Action 6:
We will play an active role in the local strategies for obesity, alcohol, tobacco and sun safety by ensuring there is target initiatives and campaigns.

Action 7:
Increase participation in the national Workplace Wellbeing Charter.

And we will
*Continue to raise awareness of the early signs & symptoms of cancer across the city (Action 8).*

*Provide targeted campaigns to promote screening for cancer (Action 9)*

# Section 3 – Early Diagnosis

Evidence | Current Position | Where do we want to get to? | What we will do

Through promoting earlier diagnosis of cancer we will improve rapid access to treatment leading to improved survival rates and therefore reducing cancer mortality. Improving early diagnosis is a multifaceted challenge and requires action across the whole pathway from public awareness, understanding and encouraging people to see their doctor, to supporting GPs and other services so that all patients have timely access to tests, specialist advice and treatment.

We aim to achieve early diagnosis through a range of methods including detection due to symptoms, detection as a result of screening using tools such as practice profiles, cancer decision toolkit and increasing diagnostic capacity. This will also include communication and engagement with the public on signs and symptoms as well as highlighting the importance of taking up NHS National screening programmes and NHS Health Checks.

This section will cover:

- Raising awareness of signs and symptoms
- Screening
- Faster investigation.

## Evidence

The 2017-2019 NHS Operational Planning and Contracting Guidance[26] states that by 2020 we will be delivering recommendations of the Independent Cancer Taskforce[27]. Through doing this we will improve one year survival rates through earlier diagnosis and patients being given a definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.

Around 1 in 4 of cancers in the UK are diagnosed through emergency admission to hospital[28] and most patients diagnosed this way have lower chances of survival compared to other patients. Late diagnosis impacts on survival rates and can be due to number of reasons including[29]:

A. Low awareness of cancer signs and symptoms can mean that people don't see the GP as soon as they might which could delay a diagnosis.
B. Some people might delay because they're worried about what the doctor might find or they don't want to waste the doctor's time.
C. There can be delays in GPs referring patients on for tests or treatment.
D. Delays can occur in getting an appointment at the hospital.

Early detection of cancer greatly increases the chances for successful treatment; this requires recognising possible warning signs of cancer and taking prompt action. There are two major components of early detection of cancer[30]:

A. Education to promote early diagnosis - this requires education amongst the general public and health care professionals of signs and symptoms of cancer and early warning signs.
B. Screening - This includes the uptake of the three national programmes breast, bowel and cervical screening. .

The coverage of Brighton and Hove's cancer screening programmes are below the England averages and national targets as demonstrated in Table 4, there is also variation between GP practices locally. Bowel Scope Screening (55yrs) is being rolled out nationally and a selection of practices in Brighton and Hove have been involved in the initial phases of this. Further work is being done nationally to implement the faecal immunochemical test (FIT) for bowel cancer screening which is an easier to use method, than that used currently, with increased sensitivity making it more likely to detect pre-cancer lesions.



[26] The 2017-2019 NHS Operational Planning and Contracting Guidance https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf
[27] Achieving Word Class Outcomes for Cancer 2015-2020 A Strategy for England; Independent Cancer Taskforce Review (2015) http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf
[28] NCIN. Routes to Diagnosis. 2010 http://www.ncin.org.uk/publications/data_briefings/routes_to_diagnosis
[29] Cancer Research UK http://www.cancerresearchuk.org/about-cancer/cancer-symptoms/why-is-early-diagnosis-important
[30] http://www.who.int/cancer/detection/en/

**Table 4: Brighton and Hove Screening Rates[31]:**

| Metric | Target | Brighton & Hove CCG | England Average |
|---|---|---|---|
| **Breast Screening** | | | |
| 50 – 70 year old women screened for breast cancer in the last 36 months (3 years) (2015/16) | 70% /80% achievable | 68.8% | 72.5% |
| **Bowel Screening** | | | |
| 60 – 69 year old men and women screened for bowel cancer in the last 30 months (2015/16) | 52%<br>60% (ideal) | 55.8% | 57.8% |
| 60 – 74 year old men and women screened for bowel cancer in the last 30 months (2015/16) | 52%<br>60% (ideal) | 56.6% | 58.5% |
| **Cervical Screening** | | | |
| 25 – 49 year old women attending cervical screening in the last 3.5 years (2014/15) | 80% | 68.2% | 71.2% |
| 50 – 64 year old women attending cervical screening in the last 5.5 years (2014/15) | 80% | 76% | 78.4% |



NICE Guidelines 12 (NG12) published in 2015 on the referral for suspected cancer superseded the NICE clinical guideline CG27 (published June 2005)[32] and implementation is a recommendation within the National Cancer Strategy. The guidelines use a new approach, focussing on the symptoms that a patient might experience and go to their doctor with making the recommendations more relevant for GPs to use. The Positive Predictive Value (PPV) of a particular symptom used to determine the threshold to refer or investigate the patient has been lowered to 3% (from approx. 5%), the result of this will be for every 100 people referred approximately 3 will have a diagnosis of cancer. The benefits of the changes to the referral guidelines are to bring:

A. Earlier diagnosis of cancer, leading to increased survival.
B. A reduction in cancers diagnosed via an emergency route.
C. Optimised diagnostic processes.

[31] Fingertips National General Practice Profiles, Public Health England https://fingertips.phe.org.uk/profile/general-practice/data#mod,6,pyr,2016,pat,19,par,E38000021,are,-,sid1,2000005,ind1,-,sid2,-,ind2,-

[32] NICE Guidance Suspected Cancer Referral and Recognition (2015) http://www.nice.org.uk/guidance/NG12/.

D. More appropriate referrals to secondary care for suspected cancer.

This guidance aims to increase the access and level of direct access diagnostics and testing prior to referral from primary care which varies between each tumour group

For early detection and awareness, Brighton and Hove needs to tackle each element of the pathway that can lead to a delay in diagnosis as follows:

A. **Public delay-** Fear at what the doctor might find, worry about wasting the GPs time, lack of knowledge about specific cancer signs and symptoms and inability to make a GP appointment at a suitable time can all contribute to a public delay in getting medical help. A series of initiatives are proposed to tackle this including local awareness campaigns of common signs and symptoms through the further roll out and promotion of the Be Clear on Cancer national campaigns; making every contact inside and outside the health care environment count e.g. Talk Cancer programme.

B. **GP delay-** Supporting GPs to be able to spot signs and symptoms of cancer and refer appropriately and in a timely manner is critical to reducing delays at the GP surgery. There are a number of tools that can be used to support GPs such as the Cancer Risk Assessment Tool (RAT) and QCancer as well as the NG12 referral forms to refer appropriately and promptly. Local GP leadership is vital to making sure these tools are received and become business as usual.

C. **System delay -** Insufficient and inappropriate use of capacity in secondary care to meet rising referral demand can also play a role in delaying the time it takes to get a diagnosis. Delivering best practice and robust pathway management using tools such as access policies, milestones, timeframes and escalation trigger points are essential tools to enable providers to deliver the 62 day urgent GP referral to treatment national target e.g. improving direct access for GPs and consistency across the county

D. **Targeted initiatives for high risk populations** across Brighton and Hove, wide variations in cancer outcomes exist and inequalities persist in communities living side by side driven by factors including ethnicity, gender and socio-economic status. Targeted interventions are commissioned to reach high risk populations and reduce variation across services to improve outcomes. This will support preventing breaches in cancer wait times, tackling inequities and deliver improved outcomes.

## Current Position

Our overarching aim is to improve early diagnosis through education of the public on signs and symptoms as well as health professionals to improve outcomes. We have a number of examples of good practice in Brighton and Hove that we can continue to develop:

A. We have commissioned in partnership (Brighton and Hove CCG and Public Health) an early awareness service for cancer to educate the public and health care professionals on the signs and symptoms of cancer and increase uptake of the NHS National Screening Programmes.
B. We continue to promote national campaigns and localise campaigns to improve awareness and understanding
C. We have developed a transgender screening leaflet to increase awareness to professional and public.
D. We have a locally commissioned service for cancer within primary care to pro-actively follow up with people eligible for NHS National Screening Programmes (Breast, Bowel and Cervical) who have not attended and are eligible.
E. We are working with GP practices to participate in national audits to improve early diagnosis by reviewing late presentations and emergency admissions of cancer. For example the National Cancer Early Diagnosis Audit and to review new cancer diagnoses and perform significant event analysis for any delayed diagnoses or emergency presentations as part of the Cancer LCS.
F. We have worked with Brighton and Sussex University Hospital (BSUH) and neighbouring CCG's to develop a plan to implement NICE Guidance NG12 locally for 1 April 2017.
G. We have created an education programme to improve knowledge within primary care on signs and symptoms of cancer.
H. We have a Cancer Research UK Facilitator who is working with health professionals in primary care to increase awareness and understanding of their cancer data, the National Screening Programmes, and support tools to improve outcomes
I. We have embedded within primary care clinical and non-clinical champions to drive the cancer agenda forward

But we know:

A. There is still variation across primary care on uptake on NHS National Screening Programmes (Breast, Bowel and Cervical)
B. We could do more to prevent late diagnosis through targeted work for certain tumour site groups and populations who present late
C. Unprompted recall of a number of common Cancer signs and symptoms is significantly higher in the UK compared to the residents of Brighton and Hove which is greater in areas of deprivation. [33]
D. We could do more through community outlets such as pharmacies to raise awareness of signs and symptoms
E. We need to build more capacity within diagnostics services to meet the needs of the population
F. We need to work across the system to improve access to services

[33] A Cancer Awareness Measure Survey was conducted in 2015 highlighting that more work was required on raising awareness of signs and symptoms of cancer.

G. We need to do more to promote cancer clinical support tools within primary care
H. We need to work with primary care to ensure patients are aware that they are on a cancer pathway and the importance of attending urgent appointments within two weeks.

## Where do we want to get to?

A. We want to increase awareness, knowledge and confidence about the signs and symptoms of cancer and effecting behavioural changes to increase the numbers seeking early professional help, particularly in the most deprived areas.
B. We want to provided targeted campaigns to populations which we know are presenting late
C. We want to ensure that we have confident and competent workforce who are aware of the signs and symptoms of cancer.
D. We want to raise public awareness of the screening programmes by providing enough information so that people can make an informed choice
E. We want to Increase awareness of and number of people attending, NHS National Screening Programmes (Breast, Bowel and Cervical)
F. We want to improve the number of people being diagnosed with cancer at an early stage
G. We want to ensure people are aware when referred on the suspected cancer pathway on the importance of attending urgent appointments and support available
H. We want to improve access to diagnostics to enable timely detection and diagnosis of cancer
I. We want to improve uptake and appropriate use of direct access testing within Primary Care.
J. We want to better integrate cancer audit activities within GP practices to strengthen processes for audit and appraisal e.g. 2 week wait utilisation and conversions.
K. We want to work towards the delivery of the 28 day to diagnosis or the exclusion of cancer by 2020.

# What we will do

Action 8:
We will continue to raise awareness of the early signs & symptoms of cancer across the city.

Action 9:
We will provide targeted campaigns to promote screening for cancer

Action 10:
We will work with Public Health England on improving screening uptake to meet national targets

Action 11:
We will provide proactive follow up to non-responders of NHS National Screening Programmes within Primary Care, building upon best practice.

Action 12:
We will work with GP practices to utilise cancer support tools to identify patients at risk of cancer



Action 13:
We will act upon the themes that come from cancer audits.

Action 14:
We will work towards the national target of 28 days to diagnosis or exclusion of cancer.

Action 15:
We will work across CSESA, STP and Cancer Alliance to ensure there is adequate diagnostic capacity.

Action 16:
We will implement and monitor the impact of NICE Guidance 12; Suspected Cancer Referral and Recognition

And we will:
*Carry out a wider Training Needs Analysis to access the workforce need across the cancer pathway (Action 39)*

*Develop a local training strategy to develop the wider workforce (Action 40)*

# Section 4 – Patient Experience

Evidence for Change | Current Picture | Where do we want to get to? | What we will do

Patient experience and the voice of those affected by cancer is essential in the transformation of cancer services. We will aspire to improve the pathway for patients to ensure their journey is seamless.

This section covers:

- Electronic access to treatment records
- Access to clinical nurse specialists (CNS)
- Cancer patient experience survey

## Evidence for change

The independent Cancer Taskforce heard throughout their engagement on the national cancer strategy, how distressing poor experiences can be and heard concerns from patients particularly about poor communication; how healthcare professionals spoke with them, the information and support they were given to help manage their health and consequences of cancer in their wider lives, and the way they were able to access information.

Patient experience overall was good however there was a significant amount of variation across the country and between different population groups. One of the key ambitions of the taskforce is to understand these variations so that they can be effectively addressed.

In 2015 71,186 people took part in a Cancer Patient Experience survey (CPES). This level of response has been consistent through the years (since its introduction in 2010) and shows how patients value this survey and understand the importance of their voice in driving change and improvement.



Communication was highlighted as a major influence on patient experience and the Taskforce believes that we should be making better use of the digital revolution where patients can have online access to their test results and other communications throughout their treatment and care.

The national report identifies areas which Brighton and Hove can make improvements on. In Brighton and Hove 77% said that they found it easy to contact their Clinical Nurse Specialist (CNS) (compared to 87% nationally) and 36% said that they were given understandable information about whether radiotherapy was working (compared to 60% nationally).

The experience of cancer patients in England is generally very positive. Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.7. On nearly half of the questions in the survey, over 80% of respondents gave positive responses. Brighton, Sussex and University Hospital (BSUH) had an average rating of 8.6. Eighty six percent of people rate their overall care as excellent or very good. The England average is 89%. People rate each aspect of their care differently: e.g. 68% reported that hospital and community staff always worked well together (compared with the England average of 63.5%).

In 2016 Healthwatch undertook a review of the cancer services at The Royal Sussex County Hospital. The review found patients were extremely positive about the quality of care. Appointments appeared to be well managed. However, delays were experienced on the day of appointment in

the Chemotherapy department with almost a third of patients (30%) not seen on time. Patients also reported delays in appointments earlier in the referral pathway prior to reaching the Cancer Centre.

In January 2016 Brighton and Hove CCG participated in the Macmillan national pilot of Commissioning for a Better Patient Experience (CBPE) project. Brighton and Hove CCG trained 7 patients as peer researchers who conducted face to face interviews alongside an online survey. There were 6 areas identified where improvements could be made; carers, financial and practical advice, access to useful information, online social networking, remote access to patient information and access to psychological peer support.

The GP Patient Survey (GPPS)[34] is an England-wide survey, providing practice-level data about patients' experiences of their GP practices. 13,328 questionnaires were sent out in Brighton and Hove, and 4,528 were returned completed. This represents a response rate of 34%. The latest figures show that 89% of respondents rated their experience of their GP surgery as good, 74% said that they found it very easy or fairly easy to get through to someone at their practice on the phone. Nearly half (49%) didn't know what services they were able to access online for their practice and 84% had not used online services in the past 6 months. 78% were able to make an appointment or speak to some last time they wanted to see or speak to a GP or nurse, 11% could also speak to someone but had to call back closer to or on the day of those 93% said that the appointment was at a convenient time for them. .

Patient experience can also be measured through the BSUH Safety and Quality scorecard. The Trust has developed a composite Board Scorecard which provides a monthly report for Board members to evaluate and consider performance over the past 12 months[35]. The report comprises the following data: mortality; the safety thermometer; incident reporting; the Friends and Family Test (FFT) score; complaints and Patient Advisory Liaison Service data; and patient feedback from the Patient Voice. The indicators are:



- **I will be treated with kindness and compassion:** The lowest score was in November 2016 with an indicator of 4.78. April 2016, May 2016 and March 2017 saw the best scores all being 5 (being the best)
- **Patient Experience (Friends and Family Test) - proportion of inpatients who would not recommend their ward:** 11/ 12 months (April 2016- March 2017) had the scores of 0 (best score) and the only exception was in Feb 2017 with a score of 3.85
- **Involved in decisions:** Scores ranged from 4.41- 4.94. November 2016 had the lowest score of 4.41 and March having the highest of 4.94. These scores have fluctuated throughout the year with no obvious trend.
- **Complaints received**: There were 47 complaints relating to cancer from April 2016 to March 2017. January saw the lowest number of complaints with 0 and September saw the largest number of complaints with 8. Over the year 7 were relating to staff attitude, 6 about the patients diagnosis, 23 relating to clinical care, 19 about staff communication,
- **PALS enquiries:** There were 66 PALs enquiries (exc Plaudits). 2 in relation to staff attitude, 17 communication, 1 about patient care There were 11 PALs plaudits

[34] https://gp-patient.co.uk/slidepacks/July2016
[35] January 2016 – December 2016

## Current Picture

A. We have a committed workforce which strives to improve pathways and experience for patients.
B. Patients reflect upon their cancer care as generally good
C. We are acting on the findings from The National Patient Cancer Survey 2015
D. The Macmillan Horizon Centre has opened in Brighton and Hove which offers range of support for people affected by cancer including, information, advice and support, complementary therapies and a range of services.
E. There are a range of support groups in the community for various tumour site groups
F. We are committed to involving patients in the development of services and are developing a strategy to run alongside this strategy.
G. BSUH have been part of pilot on implementing a patient portal which is a secure web space where patients can bring together the people and information they need to help manage their care.[36].
H. We have acted upon solutions that were established through the commissioning for better patient experience and continue to develop this piece of work.

But we know that:

A. Patients are still finding it hard to access services across the pathway including, primary care and clinical nurse specialists (CNS)
B. Patients can often have appointments cancelled due to pressure on urgent care
C. There are delays in accessing services across the cancer pathway
D. We could do more to ensure patients are communicated with as they often feel that they have not been fully informed of what is happening and require better information
E. We could do more to ensure community outlets such as pharmacies are aware of support available (e.g. Macmillan Horizon Centre) for those affected by cancer
F. We could do more to improve support for mental and emotional health and wellbeing for patients and their carers
G. We need to do more to understand the needs of people affected by cancer including support for family, carers and friends.



[36] The tool has been developed by Cancer Research UK and Patients Know Best (PKB) and brings together to provide integrated care and patient empowerment which is a key recommendation with the Independent Cancer Taskforce Review (2015) of people have online access to their records. BSUH have offered it to patients who have 'Late effects of Pelvic Radiotherapy' project, although this has been done with a small number of patients it has enabled clinical nurse specialists and patients to communicate and assess remotely which has been beneficial to this group . Patients are able to track many symptoms and specific 'consultations' can be sent to provide more detail. Follow up support via has also been offered through PKB for with colorectal/anal cancer. This has enhanced remote follow up support.

## Where do we want to get to?

A. We want to ensure that patients feel listened to and that individual needs are being met.
B. We want to improve access to CNS, ensuring patients know how to contact their CNS and that they are able to get hold of them in a timely manner.
C. We want to make sure that carers are in receipt of emotional and practical support with much better coordination at discharge so that carers and patients understand how to administer any treatment/ medical equipment.
D. We want to make sure there is adequate support for the bereaved.
E. We want to ensure that people have access to financial and practical advice
F. We want to ensure that the information developed for patients is done in collaboration to ensure it is accessible
G. We want to work towards remote access to patient information making sure patients don't have repeat information. An example of this is the patient portal.
H. We want to ensure there is access to psychological peer support through proactive signposting to support groups.

## What we will do

Action 17:
We will improve access to clinical nurse specialists

Action 18:
We will work with partners to provide emotional and mental wellbeing support for people affected by cancer

Action 19:
We will work with partners to ensure there is adequate support for carers

Action 20:
We will develop a new model of care to improve discharge processes from care

Action 21:
We will work with partners to ensure there is adequate information for patients and carers who are affected by cancer

Action 22:
We will ensure that there is access to the Sussex Interpreting Service (SIS) Volunteer Linguists who can act as intermediaries

Action 23:
We will produce a strategy for embedding patient involvement into the work we do through this strategy

Action 24:
We will continue to review patient experience surveys and take act upon the findings

Action 25:
We will roll out the patient portal to other tumour site groups and build on the areas it has been piloted (urology, colorectal and haematology)

And we will
*Develop health and wellbeing clinics to increase coverage and uptake through providing a range of options to make the more accessible and meet the needs of the local population. (Action 28)*

# Section 5 – Living with and beyond Cancer

Evidence for change | Current Picture | Where do we want to get to? | What we will do

As more people are living with and beyond cancer through early diagnosis and improved treatment increasing survival rates we need ensure there is support in place for people who have been affected to meet their needs.

We aim to ensure that people affected by cancer have a good quality of life by making sure that holistic need assessments and cancer care reviews take place to inform treatment plans and support recovery. Cancer not only impacts on the patient but family, friends and carers and it is important that they also receive the relevant support and information.

This section will cover the:

- Recovery Package
- Tailored follow-up
- Palliative care

## Evidence for Change

Due to ever improving survival rates more and more people are surviving for longer or beyond cancer. "….if someone is diagnosed with cancer, they should be able to live for as long and as well as possible, regardless of their background or where they live. Everyone who gets cancer is different. And the care and support they will need to live with a cancer diagnosis in a way that makes sense for their own life, particularly after treatment has finished, will be different."[37]

In the UK there are about 2.5 million people that have had a cancer diagnosis, about half of those diagnosed with cancer today will live for at least 10 years.

NHS England have been working closely with Macmillan Cancer Support to roll out the recovery package which describes a set of actions that ensure that the individual needs of all people going through cancer treatment and beyond are met by tailored support and services. Cancer Alliances formed of clinical leaders and patients will drive these improvements in care and support.



NHS England's 2016/2017 priorities are:

A. Agree an approach for collecting data on long term quality of life for cancer patients (National metric to roll out 2018)
B. Drive the spread of risk-stratified follow-up pathways
C. Reduce and manage long term consequences of treatment
D. Pilot the use of holistic needs assessments

Leading a physically active lifestyle both during and after cancer is linked to an improvement in many of the adverse effects of cancer and its treatments. The benefits of leading a healthy lifestyle include reducing fatigue, anxiety, depression as well as protecting the heart, lungs and bones. In some cases being physically active has led to a slowing down of the disease progression, improved survival rates and reductions in reoccurrence.[38] In some cases only 23% of people living with cancer are active to the recommended levels.[39] Physical activity

[37] Achieving World Class Cancer Outcomes: Taking the strategy Forward (May 2016)

[38] Holmes, MD et al. Physical activity andsurvival after breast cancer diagnosis. *JAMA*.25 May 2005. 293(20):2479–86. ; Meyerhardt JA, Giovannucci EL, Holmes MD, Chan AT, Chan JA, Colditz GA, Fuchs CS. Physical activity and survival after colorectal cancer diagnosis. *J Clin Oncol.* 2006. 24:3527–3534. Kenfield SA, Stampfer MJ, Giovannucci, E, Chan JM. Physical activity and survival after prostate cancer diagnosis in the health professionals follow-upstudy. *J Clin Oncol.*2011. 29:726–732

[14] Achieving World Class Cancer Outcomes: Taking the strategy Forward (May 2016)

should be included in the recovery package. One in four people who have been treated for cancer live with ill health or disability as a consequence of their treatment. For example, around a fifth of patients treated for bowel cancer have ongoing problems with bowel control, more than half of patients treated for prostate cancer suffer from erectile dysfunction and a further 38% from urinary incontinence. Cancer can affect areas of a person's life, including relationships, work, and finances – 83% of people say they are financially impacted by cancer.

## Current position

We have elements of the recovery package in place which we can build on, some of the areas we have developed are:

A. A locally commissioned service for cancer within primary care aims to ensure that patients receive a cancer care review within 6 months on diagnosis and offered on completion of treatment
B. Piloted a physical activity programme for people living with and beyond cancer which has received a positive evaluation from patients. In the 10 months the pilot was live August 2015 to May 2016, 192 clients registered with the programme, there were 172 initial 1-2-1s completed and 606 attendances at the 14 group classes provided. We will be procuring this service in 2017/18.
C. We have engaged through the Commissioning for Better Patient Experience project on the recovery package on areas that require development
D. There is a national and local focus on developing the recovery package, with monies being bid through the cancer alliance to develop this.
E. A range of palliative care services within the city including a telephone hub for patients and practitioners which has seen more people supported to die at home rather than in hospital

But we know:

A. There is still variation in treatment summaries provided per tumour site group
B. There is still variation in how health needs assessments are carried out per tumour site group.
C. There is still variation within number and quality of cancer care reviews taking place within Brighton and Hove
D. We could do more to address the impact of cancer and mental wellbeing
E. We need to develop stratified pathways across tumour sites
F. That Clinical Nurse Specialists are under pressure and can't always be accessed
G. We need to build upon the patient portal through extending this to other tumour site groups
H. We need move activity away from the hospital and into the community
I. We need to do more to understand the needs of people affected by cancer e.g. support for family, carers and friends.

[39] Thomas RJ, Holm M, Al-Adhami A. Physical activity after cancer: An international review of the literature. BJMP. 1st ed. 2014 Mar 2;7(708):1–7.

## Where do we want to get to?

A. We want to ensure patients are supported in making informed choices about their preferred priorities of care.
B. We want to provide a high quality and accessible recovery package that meets the need of the population.
C. We want to ensure all patients have a holistic needs assessment and care plan at the point of diagnosis;
D. We want to ensure treatment summaries are sent to the patient's GP at the end of treatment which will standardised across tumour site groups; and
E. We want to ensure a cancer care review is completed by the GP within six months of a cancer diagnosis and offered when treatment is completed
F. We want to develop a host of health and wellbeing clinics to provide education and support through different formats to meet people's needs.
G. We want to ensure that we are proactively engaging with people effected by cancer to meet their needs
H. We want to ensure that we have a range of services to improve quality of life
I. We want to build upon best practice and evidence based interventions.
J. We want to ensure that people have access to their treatment summaries and appointments through the use of technology.
K. We want to improve accessibility to advice and support.
L. We want to ensure that everyone in Brighton and Hove has equal access to high quality palliative and end of life care in a variety of settings based on need, regardless of their diagnosis or the point at which they enter the healthcare system.
M. We want to improve the number of cancer patients dying in their place of choice
N. We could do more to train the wider workforce on how to support patients who are palliative of at the end of life.

## What we will do

Action 26:
We will standardise and improve the quality of holistic needs assessments at diagnosis

Action 27:
We will Standardise and improve coverage and quality of treatment summaries,

Action 28:
We will develop health and wellbeing clinics to increase coverage and uptake through providing a range of options to make the more accessible and meet the needs of the local population.

Action 29
We will improve the coverage, uptake and quality of cancer care reviews in primary care.

Action 30
We will commission a Physical Activity, Signposting and Recovery Package Support service for People affected by Cancer following the success of the pilot.

Actions 31:
We will develop stratified pathways, recognising their dependency on the availability of the Recovery Package

Action 32
We will Support managed follow up and or discharges of cancer survivors to within the community setting

Action 33:
We will develop plans to reduce crisis admissions for cancer patients

Action 34:
We will work as part of the CSESA, STP and Cancer Alliance on how cancer support and follow-up can be integrated with the on-going management of other long term conditions

Action 35:
We will ensure all staff feel increasingly confident and able to provide seamless and high quality services for patients whose disease or personal circumstances are complex and changing.

Action 36:
We will continue to promote the proactive care form/ end of life template to support management of patients in primary care at the end of active treatment

Action 37:
We will work to increase the numbers of patients dying in their place of residence.

Action 38:
We will increase and continue engagement with third sector and patient support groups



And we will:
*Produce a strategy for embedding patient involvement into the work we do through this strategy (Action 23)*

*Carry out a wider Training Needs Analysis to access the workforce need across the cancer pathway (Action 39)*

*Develop a local training strategy to develop the wider workforce (Action 40).*

# Section 6 – Modernising Cancer Services

Evidence for change | Current Picture | Where do we want to get to? | What we will do

Achieving the very best outcomes will be dependent on the effort, dedication and passion of every part of the health and care system. This means that we must provide modern, high-quality equipment and environments, ensure access to the best treatments possible, and support and motivate our workforce.[40]

The National Cancer Strategy highlight the need to make the necessary investments required to deliver a modern, high quality service. This is dependent on the effort, dedication and passion of every part of the health and care system. NHS England recognises that they need to provide modern, high-quality equipment and environments, ensure access to the best treatments possible, and support and motivate our workforce such as the need to modernise radiotherapy machines.

This section covers.

- Developing the local workforce to have the right mix of skills, competencies and experience
- Strategic approach to workforce planning
- Bring care into the community
- Cancer drugs
- Supporting cancer research and access to clinical trials



[40] Achieving World Class Cancer Outcomes: Taking the strategy Forward (May 2016)

## Evidence for change

In order to achieve any improvements in outcomes for patients and their families/ carers we need to make sure we have the right workforce with the right competencies in place in conjunction with the right equipment they need to carry out their duties.

In Brighton and Hove the Cancer Patient Experience Survey (CPES) showed that although the patient has a Clinical Nurse Specialist (CNS) they were not always able to contact them.
Nationally 90% of respondents were given the name of CNS which is the same percentage for Brighton and Hove, 87% Nationally said that it had been ‘quite easy’ or ‘very easy’ to contact their CNS but the figure for Brighton and Hove is 77%. Nationally 88% said when they had important questions to ask that they had got answers they could understand most of the time this figure is 85% for Brighton and Hove.

A training needs analysis recently highlighted the views of the professionals within primary care who responded to a survey as part of our recent education programme showed 48% felt that they needed more training on the support services available to patients both within and outside of the NHS. 44% of respondents would like training to support them to discus with the patient and their family their anxieties about a cancer diagnosis, prognosis, the dying process and what will happen. The respondents also asked for more opportunities for training on screening programmes as well as further information on some site specific cancers including lung, breast and prostate cancers.

The National Cancer Strategy makes it clear that, development and assurance of the future workforce will be paramount to a sustainable high quality service with Health Education England developing model of care which shape skills mix of the workforce required to deliver a modern, holistic patient-centred cancer service.

NHSE recognises that in order to provide the very best radiotherapy treatment to patients they need to urgently address the need to modernise radiotherapy machines.

The Kent, Surrey and Sussex Clinical Research Network (KSSCRN) incorporates Brighton and Hove and supports local research priorities for the area.

## Current Position

A. We have an enthusiastic, energetic and willing wider workforce, committed to finding the best possible solutions for people effected by cancer
B. We have a broad range of good quality, evidence-based interventions and treatment across the cancer pathway
C. BSUH funded a new linear accelerator radiotherapy machine
D. We have an locally commissioned service for the administration of LHRH for prostate cancer
E. We have a training programme in place for part of the development of LCS which we will continue to develop to our primary care workforce.
F. We have some new initiatives which are developing staffs roles and responsibilities and may require additional skills to work effectively e.g. support workers and practice nurses carrying out cancer care reviews.
G. We are currently reviewing how we can build surveillance and monitoring of cancer into the community such as stable PSA levels
H. We are working with the SECN on developing the allied health professional role to support cancer patients and build upon the model of care.
I. That access to new drugs is being determined through NHS England's clinical commissioning policy process, with a mechanism for those drugs with uncertain potential to be considered for inclusion within the Cancer Drugs Fund.
J. There is a robust process for the formal adoption of NICE approved technology appraisals via the area prescribing committee and the joint formulary
K. Brighton and Sussex University Hospital NHS Trust recruited 356 patients to cancer trials in 2016/17

But we know

A. We have stretched workforce who are currently trying to meet the demand
B. There is a shortage of staff across the health service to meet demand e.g. clinical nurse specialists, radiographers, endoscopists
C. It is essential that healthcare professionals and other staff across health and social care have the right skills, knowledge and competence to provide high quality cancer care.
D. Equipment needs replacing within providers (this is also the case nationally)
E. KSSCRN is the lowest recruiting research network per capita for clinical trials, and pressures on service threaten research capacit

## Where do we want to get to?

A. We would like to work with the workforce to understand their training needs
B. We would like to have a workforce in the community that understanding signs and symptoms of cancer but also how they can support cancer patients post diagnosis
C. We would like to have adequate workforce to meet the demand on services to ensure patients are seen in a timely way
D. We would like to see movement of activity into the community where appropriate to ensure care is closer home
E. We would like that there is adequate equipment to meet the demand
F. We would like there to be a range of treatment options for patients
G. We would like to improve access to cancer clinical trials by 10% from 2016/17 or meet targets per 100,000 served as set nationally

## What we will do

Action 39:
We will carry out a wider training needs analysis to access the wider workforce need across the cancer pathway e.g. community services

Action 40:
We will develop a local training strategy to develop the wider workforce

Action 41:
We will work with Health Education England to identify local training and workforce needs

Action 42:
We will Work with the Cancer Alliance to look at how we can utilise the workforce such as allied health professionals

Action 43:
Work with NHSE to ensure that there is adequate equipment

Action 44:
We will continue to work with medicine management and NHSE to understand the development of new cancer drugs and access to these. including through clinical trials.

Action 45:
We will support the cancer research agenda and access to clinical trials in priority areas for Brighton and Hove

# Section 7 – Commissioning, accountability and provision

Commissioning | Current Position | Governance | What we will do

Enablers such as robust governance and leadership at all levels across Brighton and Hove is essential to deliver improved outcomes which includes collaborative working across  key stakeholders such as the public, patients and the third sector. This will be required to drive through delivery in primary, community and secondary care

This section will cover:

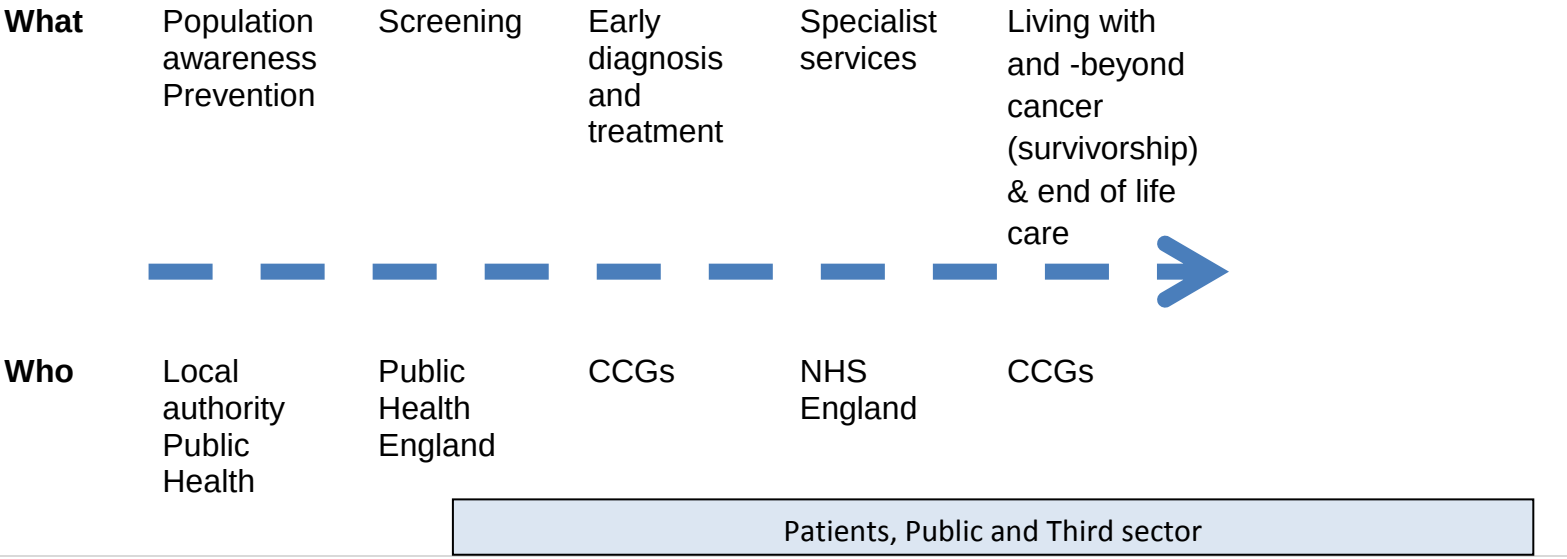
- Cancer Alliances
- STP and CSESA
- Governance

## Commissioning

April 2013, brought changes to the NHS with new commissioning arrangements covering the various parts of the cancer pathway as follows:

- **Public Health** teams within Local Authorities have taken on responsibility for prevention and population awareness of cancer signs and symptoms
- **Clinical Commissioning Groups** (CCGs) have responsibility for the commissioning of common cancer services as well as early diagnosis, services for patients living with and after cancer as well as end of life care
- **NHS England** has responsibility for the direct commissioning of specialist services including chemotherapy and radiotherapy and primary care (co-commissioning to commence in Brighton and Hove)
- **Public Health England** has responsibility for population screening





## Current Position

Brighton and Hove CCG is part of a wider commissioning "footprint" with CCG's in Sussex and East Surrey[41] to deliver a Sustainability and Transformation Partnership ("STP")[42]. The STP cover a large and diverse region, with 23 organisations serving 1.7m people and recognises that there are significant challenges across the system including waiting times and cancer outcomes, alongside a relatively older population. There are several ambitions within the STP including improving health and wellbeing of the population, prevention, integrated care, shared records and more specialised services within the community. Underneath the STP there are three "Place-Based" areas each defined around local communities, empowered to co-design person-centred services, led by GPs with support from a wide range of professionals. Brighton and Hove CCG is part Central Sussex[43] and East Surrey Alliance Place based plan[44] which places integration at its centre, providing care and services closer to home. This could be done through a multispecialty community provider model.

It is recognised that it will be a challenge is to improve the health of our communities, make it quicker and easier to access services, to deliver improvements identified by regulators and find a way to do so within a tighter budget.

The formation of the Surrey and Sussex Cancer Alliance in 2016 is responsible for the local cancer agenda, monitoring local performance, and tasked with leading improvement in cancer outcomes for their population. The Cancer Alliance brings together system leaders to meet the recommendations in the National Cancer Strategy and will focus on initially on improving early diagnosis, the recovery package and the development of stratified pathways.



[41] This includes East Surrey CCG; Crawley CCG; Horsham and Mid Sussex CCG; Coastal West Sussex CCG; Brighton and Hove CCG; High Weald Lewes Havens CCG; Eastbourne Hailsham and Seaford CCG; Hastings and Rother CCG, Surrey County Council; West Sussex County Council; Brighton and Hove City Council; East Sussex County Council., First Community Health & Care; Queen Victoria Hospitals NHS Trust; Surrey and Sussex Healthcare NHS Trust; Sussex Community Foundation NHS Trust; Sussex Partnership Foundation NHS Trust; South East Coast Ambulance Service Foundation NHS Trust; Surrey and Borders Partnership Foundation Trust; Integrated Care 24; Western Sussex Hospitals NHS Foundation Trust; Brighton and Sussex University Hospitals NHS Trust; East Sussex Healthcare NHS Trust; GP providers

[42] The Sustainability and Transformation Plan Sussex and East Surrey 'footprint' (2016) http://www.brightonandhoveccg.nhs.uk/your-services/sustainability-and-transformation-plan

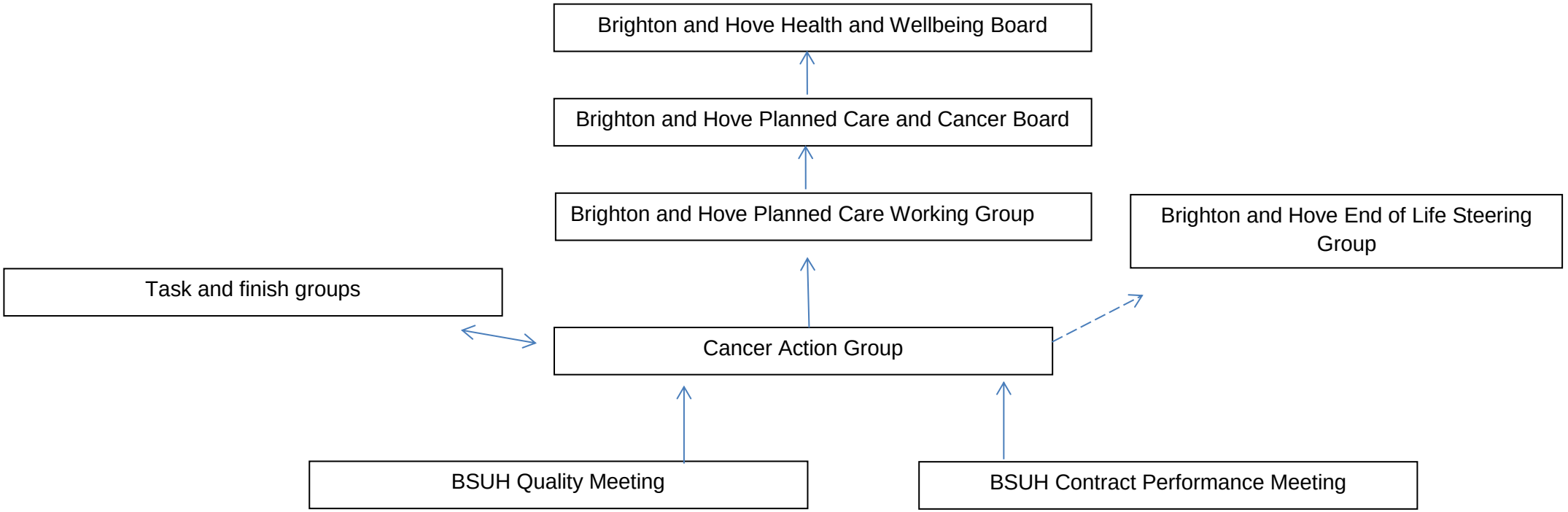
[43] This includes Brighton & Hove, High Weald Lewes Havens, Horsham & Mid Sussex, Crawley and East Surrey

[44] The Central Sussex and East Surrey Alliance (CSESA) Place Based Plan (2016) http://www.brightonandhoveccg.nhs.uk/your-services/sustainability-and-transformation-plan

# Governance

We have Cancer Action Group to oversee our strategy and deliver the recommendation. We will continue to develop our membership which is drawn from a range of organisations and partners which has clear Terms of Reference and a clear reporting line to the Brighton and Hove Planned Care and Cancer Board.

**Governance for Brighton and Hove Cancer Action Group**



The Cancer Action Group was established to work collaboratively across integrated systems to deliver safe and effective care, improve cancer clinical outcomes and enhance patients' and carers' experience and quality of life. It focuses on increasing the uptake of screening, early diagnosis, survival of cancer and improve the patient experience of services and quality of life of people affected by cancer.

The Cancer Action Group will be responsible for monitoring progress against the action plan in this strategy and will form task and finish groups to meet the actions outlined. A risk log will be maintained with mitigating actions and will be regular reported on and reviewed.

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As demonstrated through this strategy there are several services commissioned to meet local population needs. All services have key performance indicators (KPI's), quality standards and outcome measures to monitor the effectiveness of the service and areas for development. Each Provider has regular contracting and quality meetings to review the service and address any issues.

NHSE is in developing a new Cancer Dashboard which will include new metrics such as the faster diagnosis standard and the long-term quality of life metric. Locally we have started to develop a dashboard to enable us to measure the impact of services on the cancer pathway.

## What we will do

Action 46:
We will continue to develop and review the membership for the Cancer Action Group to ensure it covers the whole cancer pathway

Action 47:
We will develop best practice pathways to reduce variation and improve overall quality

Action 48:
We will ensure that providers have clear KPIs and outcomes to enable us to map the cancer pathway

Action 49:
We will further develop relationships with NHSE to align commissioning intentions and improve patient outcomes

Action 50:
We will implement appropriate national guidelines to ensure standard pathways
And we will:

*Work across CSESA, STP and Cancer Alliance to ensure there is adequate diagnostic capacity (Action 22)*

# Section 8 Action Plan and Glossary

Baseline improvement

Action Plans

Glossary

## ACTION PLAN

| No | Action | Milestones | Risk level /Priority | Inter-dependencies | Timescale* | Lead |
|---|---|---|---|---|---|---|
| **Section 2 –Prevention** | | | | | | |
| 1 | We will continue to promote healthy lifestyles across the city. | • We will continue to promote the work of the Healthy Lifestyles team in the City and offer this service to residents especially those living in the most deprived areas.<br>• Increase the number of people accessing community, pharmacy & GP practice based smoking cessation services. | Low | Local services Pharmacies & GP practices | On-going | BHCC |
| 2 | Work with primary care to reduce variation in preventative services provided through Locally Commissioned Services& increase the uptake of heath improvement | • We will join up the commissioning of services in primary care through joint planning and contracting processes.<br>• We increase the uptake of NHS Health Checks though targeting those surgeries | Medium | BH CCG Primary Care | From April 2017 Review April 2018 | BHCC |

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| | services particularly for those living the more deprived areas. | where it is low. | | | | |
| 3 | We will update the JSNA for Brighton and Hove to ensure that our commissioning plans are informed by the latest intelligence on prevalence, incidence and outcomes. | | Low | BHCCG | June 2017 | BHCC |
| 4 | We will continue to develop Healthy Living Pharmacies across the city | • We increase the number of Healthy Living pharmacies across the City. | Medium | Pharmacies | From April 2017 Review April 2018 | BHCC |
| 5 | We will skill up the workforce to provide brief advice and interventions in Making Every Contact Count | • We will work with the wider workforce through training (Action 40) | Medium | Primary Care Providers Community Outlets | From April 2017 Review April 2018 | BHCC |
| 6 | We will play an active role in the local strategies for obesity, alcohol, tobacco and sun safety by ensuring there is target initiatives and campaigns | • We will provide targeted campaigns to reduce smoking prevalence in adults and young people | Medium | Primary Care Providers Community Outlets | April 2017 | BHCC |
| 7 | We will increase participation in the national Workplace Wellbeing Charter | • We will work with local businesses & organisations to increase the accreditation of the Charter. | Low | Local businesses & organisations. | From April 2017 Review April 2018 | BHCC |
| **Section 3- Early Diagnosis** | | | | | | |
| 8 | We will continue to raise awareness of the early signs & symptoms of cancer across the city. | • We will work with commissioned services to ensure information is accessible<br>• We will provide 4 or more targeted campaigns a year<br>• We will work with the wider workforce on raising awareness through training | Low | BHCC BHCCG AITC Primary Care Community outlets Providers | From April 2017 Review April 2018 | BHCC BHCCG |

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| | | (Action 40) | | | | |
| 9 | We will provide targeted campaigns to promote screening and signs and symptoms of cancer | • We will develop a campaign and communication plan for the year<br>• We will work with the Early Awareness Service to evaluate campaigns | Medium | BHCC<br>BHCCG<br>AITC<br>Primary Care<br>Community outlets<br>Providers | April 2017 | BHCC/ BHCCG |
| 10 | We will work with Public Health England on improving screening uptake to meet national targets | • We will play a proactive role in attending PHE Screening Board Meetings<br>• We will work with PHE to develop services locally<br>• We will work with the CRUK facilitator to visit practices to provide information on their practice screening data and how they could improve uptake. | Medium | PHE<br>Primary Care<br>Screening Hubs | From April 2017<br>Review April 2018 | BHCC/ BHCCG |
| 11 | We will provide proactive follow up to non-responders of NHS National Screening Programmes within Primary Care building upon best practice | • We will roll out the LCS following the Pilot phase to all practices<br>• We will evaluate the LCS impact and uptake. | High | Primary Care | April 2017<br><br>April 2018 | BHCCG |
| 12 | We will work with practices to utilise cancer support tools to identify patients at risk of cancer | • We will ensure practices have access to support tools such as Cancer Risk Assessment Tool (RAT) and QCancer through the LCS<br>• We will work with practices on uptake of the tools | High | Primary Care<br>Cancer UK Facilitator | April 2017<br><br>April 2018 | BHCCG |
| 13 | We will act upon the themes that come from cancer audits. | • NCDA cancer audit themes to be shared with practices<br>• Themes from the LCS on significant event analysis to share across practices | Medium | Primary Care<br>Cancer Research UK | June 2017 | BHCCG |

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| 14 | We will work towards the national target of 28 days to diagnosis or exclusion of cancer | • We will develop a framework to start shadow monitoring 28 days to diagnosis<br>• We will work with the cancer alliance to ensure there are systems in place to record staging at diagnosis consistently and accurately. | Low | NHSE<br>BSUH | April 2020 | BHCCG |
| 15 | We will work across CSESA, STP and Cancer Alliance to ensure there is adequate diagnostic capacity | • We will review options for developing a diagnostic hub<br>• If appropriate we will pilot a diagnostic hub<br>• Roll out of diagnostic hub | Medium | CSESA<br>STP<br>Cancer Alliance | May 2017<br><br><br><br>April 2020 | BHCCG |
| 16 | We will implement and monitor the impact of NICE Guidance 12 Suspected Cancer Referral and Recognition | • BSUH implementation plan<br>• Education to primary care<br>• NG12 is Live<br>• Monitoring framework in place<br>• Evaluation on impact of NG12 | High | BSUH | April 2017<br><br><br><br>April 2018 | BHCCG |
| **Section 4- Patient Experience** | | | | | | |
| 17 | We will improve access to clinical nurse specialists | • We will look at the role of health support workers in supporting CNS | High | Macmillan | April 2019 | BSUH |
| 18 | We will work with partners to provide emotional and mental wellbeing support for people affected by cancer | • We will work with partners to promote and ensure there is access to peer support<br>• We will make sure bereavement support available at the horizon centre | Medium | BHCCG<br>BSUH | From April 2017 | Macmillan Horizon centre |
| 19 | We will work with partners to ensure there is adequate support for carers | • We will work with agencies to ensure they are aware of peoples individual needs through training and promotion | Medium | BHCCG<br>BSUH | From April 2017<br>Review April 2018 | Macmillan Horizon Centre |
| 20 | We will develop new model of care to improve discharge processes from care | • Review the feasibility of discharge meetings with partners and carers present to discuss the next steps | Medium | BHCCG | April 2018 | BSUH |

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| 21 | We will work with partners to ensure there is adequate information for patients and carers who are affected by cancer | • We will make access to financial and practical advice available at: The Horizon Centre, GP Practices, Pharmacies, Hospital, Citizens Advice Bureau | Medium | GP Practices, Pharmacies, Hospital, Citizens Advice Bureau | From April 2017 | Macmillan Horizon Centre |
| 22 | We will ensure that there is access to the Sussex Interpreting Service (SIS) Volunteer Linguists who can act as intermediaries | • We will work with primary care to ensure interpreting needs are identified on TWW referral | Medium | BSUH<br>BHCCG | April 2017 | BHCCG<br>BSUH |
| 23 | We will produce a strategy for embedding patient involvement into the work we do through this strategy | • We will work with partners on developing the peer researcher role<br>• Patient Participation strategy has been written and will go out to consultation | High | BSUH<br>Macmillan<br>Horizon Centre<br>BHCC | March/ April 2017<br><br>September 2017 | BHCCG |
| 24 | We will continue to review patient experience surveys and take act upon the findings | | Low | BSUH<br>Primary Care | From April 2017<br>Review April 2018 | CCG |
| 25 | We will roll out the patient portal to other tumour site groups | • Evaluation of current pilot sites<br>• Implementation plan for role out | Low | Cancer Alliance<br>Primary Care | April 2018 | BSUH |
| **Section 5- Living With And Beyond Cancer** | | | | | | |
| 26 | We will standardise and improve the quality of Holistic Needs Assessments (HNA) at diagnosis | • Review current format and process<br>• Standardise template across TSSG<br>• Produce a patient and carer information pack to accompany the HNA<br>• Monitor and evaluate | High | | April 2018 | BSUH |
| 27 | We will Standardise and improve coverage and quality of treatment summaries, | • Review current format and process<br>• Standardise template across TSSG<br>• Monitor and evaluate | High | Primary Care<br>BHCCG | April 2018 | BSUH |
| 28 | We will develop health and wellbeing clinics to increase coverage and uptake through providing a range of options to make | • Review current format and process engaging with patients on what would be beneficial<br>• Work collaboratively to develop Health | High | BSUH<br>Macmillan<br>Voluntary Sector organisations | April 2018 | BSUH/ BHCCG |

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| | the more accessible and meet the needs of the local population. | and Wellbeing events<br>• Pilot different models<br>• Evaluate and roll out a programme | | | | |
| 29 | We will improve the coverage, uptake and quality or cancer care reviews in primary care. | • Development of a standardised template<br>• Primary care nurse training | Medium | Primary Care | On-going | BHCCG |
| 30 | We will commission a Physical Activity, Signposting and Recovery Package Support service for People affected by Cancer following the success of the pilot. | • We will ensure that a new service is in place by September 2017<br>• Evaluation of service | Low | | September 2017<br><br>Ongoing | BHCCG |
| 31 | We will develop stratified pathways, recognising their dependency on the availability of the Recovery Package | • We will initially role out to prostate and lung and evaluate the impact<br>• We will work with the SECN on developing thresholds and models. | High | SECN<br>Cancer Alliance | April 2019 | BHCCG/ BSUH |
| 32 | We will support managed follow up and or discharges of cancer survivors within the community setting | • We will pilot nurse led clinics | | SCFT<br>Primary Care | | BSUH |
| 33 | We will develop plans to reduce crisis admissions for cancer patients | • We will develop as part of the recovery package<br>• We will education the wider workforce<br>• See action 36<br>• See action 38 TNA<br>• See action 39 training strategy | | BSUH<br>SCFT<br>Primary Care | | BHCCG |
| 34 | We will work as part of the CSESA, STP and Cancer Alliance on how cancer support and follow-up can be integrated with the on-going management of other long term conditions | • We will play an active part in contributing to the development of new model of care | Low | CSESA<br>STP<br>Cancer Alliance<br>SECN | April 2020 | BHCCG |
| 35 | We will ensure all staff feel increasingly confident and able to | • See action 38 TNA<br>• See action 39 training strategy | Medium | HEE | April 2020 | BHCCG |

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| | provide a seamless and high quality services for patients whose disease or personal circumstances are complex and changing. | | | | | |
| 36 | We will continue to promote the proactive care form/ end of life template to support management of patients in primary care at end of active treatment | • Audit of Summary Care Record Advanced Information and Respect<br>• Ambitions for Palliative Care self – assessment carried out<br>• Monitoring through LCS | Medium | Primary Care<br>End of life steering group | April 2018 | BHCCG |
| 37 | We will work to increase the numbers of patients dying in their place of residence. | • We will work with Providers and patients to ensure end of life templates are completed and accessible.<br>• See action 39 training strategy | Medium | BSUH<br>Paramedics<br>SCFT<br>Nursing Homes | April 2018 | BHCCG |
| 38 | We will increase and continue engagement with third sector and patient support groups | • We will map services and support groups available to Brighton and Hove Residents | Low | Macmillan<br>BSUH<br>SCFT<br>Primary Care | August 2017 | BHCCG |
| **Section 6- Modernising Cancer Services** | | | | | | |
| 39 | We will carry out a wider TNA to access the workforce need across the cancer pathway | • We will extend this to allied health professionals, social care, voluntary sector and secondary care<br>• We will feed back the findings to HEE and Providers | Medium | | May 2017 | BHCCG |
| 40 | We will develop a local training strategy to develop the wider workforce | • Accessing local need through action 38<br>• We will work with providers to ensure the workforce is developed<br>• We will work with HEE to develop the local workforce | Medium | Providers | August 2017 | BHCCG |
| 41 | We will work with Health Education England to identify local training and workforce needs | | Low | | On-going* | BHCCG |
| 42 | We will Work with the Cancer Alliance to look at how we can utilise | | Low | SECN<br>Providers | On-going* | BHCCG |

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| | the workforce such as allied health professionals | | | | | |
| 43 | Work with NHSE to ensure that there is adequate equipment | | Low | BSUH | On-going* | BHCGG |
| 44 | We will continue to work with medicine management and NHSE to understand the development of new cancer drugs and access to these, including through clinical trials | | Low | | On-going* | BHCCG |
| 45 | We will support the cancer research agenda and access to clinical trials in priority areas for Brighton and Hove | | Low | BSUH | On-going* | BHCCG |
| **Section 7- Commissioning Accountability And Provision** | | | | | | |
| 46 | We will continue to develop and review out membership for the Cancer Action Group to ensure it covers the whole cancer pathway | • Wider the membership to include community services and palliative care representation | Low | | April 2017 | BHCCG |
| 47 | We will develop best practice pathways to reduce variation and improve overall quality | • Development of the LCS<br>• Mapping of pathways for each TSSG<br>• Developing clear pathways | Medium | Providers | April 2018 | BHCCG |
| 48 | We will ensure that providers have clear KPIs and outcomes to enable us to map the cancer pathway | • Applied as part the commissioning cycle and contracting | Medium | | On-going* | BHCC/ BHCCG |
| 49 | We will further develop relationships with NHSE to align commissioning intentions and improve patient outcomes | • Improved communication, data flow and regular meetings with NHSE<br>• NHSE attendance at specific partnership board meetings<br>• Review and develop new models of care | Low | NHSE | On-going* | BHCC BHCCG |
| 50 | We will implement appropriate national guidelines to ensure standard pathways | • We will work with providers to implement NICE Guidelines<br>• Ensure it is embedded into contracts | Low | BSUH SCFT BHCC | On-going* | BHCC/ BHCCG |

***Actions which are ongoing will reviewed quarterly, developed and reviewed at the Cancer Action Group.

# GLOSSARY OF TERMS

**Brighton and Hove City Council (BHCC):** has the responsibility for prevention and population awareness of cancer signs and symptoms

**BHCCG Brighton and Hove Clinical Commissioning Group (BHCCG):** have responsibility for the commissioning of common cancer services as well as early diagnosis, services for patients living with and after cancer as well as end of life care

**Brighton University Hospital Trust (BSUH):** Provides acute care for Brighton and Hove

**Cancer Action Group** A forum for collaborative working across partners and stakeholders

**Cancer Alliance** Plan cancer services in their particular population and design care pathways, provide improvement support, measure outcomes and engage with the public on cancer service changes.

**Cancer Care reviews** This is a discussion between a patient and their GP or practice nurse about their cancer journey. It helps the person affected by cancer understand what information and support is available to them in their local area, open up about their cancer experience and enable supported self-management.

**Cancer Network** An administrative body, working across organisations in an area to deliver consistency in cancer services.

**Central Sussex and East Surrey Alliance** The STP footprint made up of Crawley, East Surrey, High Weald Lewes Havens, Brighton and Hove, Horsham Mid Sussex

**Clinical Commissioning Groups CCG's –** are NHS organisations set up through the Health and Social Care Act (2012) to organise the delivery of NHS services in England.

**Emergency presentation/admission** Patients that have been seen in Accident and Emergency (A&E)
**Emotional Wellbeing** - defined as: "A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment."[45]

**Health and Wellbeing clinics** Part of the recovery package.-Supportive, group events that provide information, signposting and contact with peers

**HealthWatch** Under the NHS reforms HealthWatch will be the independent consumer champion for the public - locally and nationally - to promote better outcomes in health for all and in social care for adults. HealthWatch will be representative of diverse communities. It will provide intelligence - including evidence from people's views and experiences - to influence the policy, planning, commissioning and delivery of health and social care. Locally, it will also provide information and advice to help people access and make choices about services as well as access independent complaints advocacy to support people if they need help to complain about NHS services and will have a greater strategic role as it has a statutory place on the Health and Wellbeing Board.

**Holistic needs assessment and care Planning** Part of the Recovery Package- A Questionnaire that ensures that people's physical, practical, emotional, spiritual and social needs are met in a timely and appropriate way.

**Improving Outcomes Guidance (IOG)**

**Joint Strategic Needs Assessment (JSNA)** analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA will underpin the health and well-being strategies, a proposed new statutory requirement and commissioning plans. The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities. The NHS and upper-tier local authorities have had a statutory duty to produce an annual JSNA since 2007.

[45] World Health Organization. 2007. The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines. Geneva: WHO.

**Key Performance Indicators KPI's –** a type of performance or success measure used to evaluate the success of an organisation or particular service or activity it engages in

**Mental Wellbeing** – defined as "A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"[46]

**National Institute for Health and Care Excellence NICE -** provides national guidance and advice to improve health and social care

**Public Health England –** An executive agency of the Department of Health that was set up in April 2013 as a result of the reorganisation of the NHS in England. Its main function is to protect and improve the nation's health and wellbeing, and reduce health inequalities

**Patient Partnership Group (PPG)** The local voice of the community on health matters. Their purpose is to gather views about the quality of services, monitor service gaps and their impacts, and make suggestions on improving the experience of the user of the service

**Recovery Package** The recovery package is a series of interventions that includes Holistic Needs Assessment and Care Planning, Treatment Summary, Cancer Care Review, Health and Wellbeing events and self-management.



**Sussex Community Foundation Trust:** Provides community services for Brighton and Hove such as occupational therapy, physiotherapy, dietitians

**Sustainability and Transformation Plans** The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals, called sustainability and transformation plans (STPs), are place-based and built around the needs of the local population.

**Treatment Summaries** A document (or record) completed by secondary care professionals after a significant phase of a patients cancer treatment. It describes the treatment, potential side effects, and signs and symptoms of recurrence. It is designed to be shared with the person living with cancer and their GP

**TSSG - Tumor Site Specific Group**: A group of doctors, nurses and other allied health professionals in a network who get together to discuss the treatment of a particular type of tumour e.g. breast or lung. Patient representatives are also members

[46] World Health Organization. 2004. Promoting Mental Health: Concepts; emerging evidence; practice. Geneva: WHO.

# Appendix 1 Brighton and Hove Cancer Action Group Membership

| Representative Role | Organisation |
|---|---|
| Clinical Lead / Macmillan GP | B&H CCG |
| Commissioning Manager | B&H CCG |
| Commissioning Support Manager | B&H CCG |
| McMillian Primary Care Nurse | B&H CCG |
| Clinical Quality Manager | B&H CCG |
| Patient and Safety Manager | B&H CCG |
| Screening and Prevention | Public Health NHSE Surrey and Sussex |
| Lead Nurse - Cancer | BSUH |
| Cancer Directorate Manager | BSUH |
| Clinical Lead – Cancer | BSUH |
| Patient representative/s | Healthwatch |
| Development Manager | Macmillan |
| Screening & Prevention | Public Health B&HCC |
| Public Health Analyst | Public Health B&HCC |
| CRUK Facilitator | Cancer Research |

**Attendance by others**

CCG: Commissioners and Clinical Leads for LTC/EOLC and Planned Care *(as deemed appropriate to agenda),* Neighbouring CCG's, NHSE Specialist Commissioning. *(as deemed appropriate to agenda)* SCFT/Proactive Care/First, Community / Hospices.
BSUH: MDT Leads *(as deemed appropriate to agenda).*

# 7.5.8 Cancer



## Why is this issue important?

Cancer is the most common cause of death in England, accounting for 27% of all deaths.[1] It is also the most common cause of premature death, accounting for 42% of deaths in those aged under 75 years.[1]

The picture is similar in Brighton & Hove with cancer accounting for 28% of all deaths and 40% of deaths in those aged under 75.[2]

The incidence and deaths from cancer is increasing nationally and locally as the population lives for longer. Every year in England 300,000 people are diagnosed with cancer, an increase of over 60,000 in the past ten years and around 150,000 die from the disease.[3]

Cancer is also more common in people living in the most deprived areas. Brighton & Hove has some of the most deprived[4] areas in the South East. Just under half, 45% of the population of the city, live in the 40% most deprived areas in England and only 7% in the 20% least deprived areas.[5]

The most common cancer in females is breast and in males prostate; the second and third most common cancers in both females and males are lung and colorectal cancer.[3]

Despite improvements in cancer survival and mortality in recent decades, outcomes in the UK are poor compared with the best in Europe. A report in the Lancet in 2015 analysing common cancer 5-year survival rates[6] showed that the UK was lagging behind with rates in 2005-2009 similar to what other Western European countries had achieved ten years earlier.

If premature mortality is to be reduced, then prevention of cancer is as important as treatment. Tobacco smoking remains the most important avoidable cause of cancer in the UK, followed by diet, excess body weight; due to diet and inactivity, and alcohol consumption. Cancer Research UK estimate that 42% of cancers in the UK are preventable through lifestyle choices[7]. Exposure and conditions at work, sunlight and sunbeds, infections, radiation, not breastfeeding and hormone replacement therapy are also key risk factors. The importance of lifestyle choices can be seen when it is borne in mind that less than 5% of cancer is genetically linked.[8]

In Brighton & Hove 42% of adults drink more than the UK recommended amount of alcohol, compared to 26% for England.[10] Alcohol is linked to an increased risk of seven types of cancer yet only around one in ten people are aware of this link. In the UK we continue to drink substantially more than we did 50 years ago.[9] 52.6% of the City's adult population is overweight or obese; although lower than the England value of 64.8%, this is still over half of the City's adult population.[10] 19.9% of the adult population smoke, significantly worse than the figure for England of 15.5%. By choosing a healthy lifestyle the risk of cancer can be reduced.[11,12]

In terms of cancer screening the national screening programmes aim to detect cancer early when treatment is more likely to be effective. Cancer Research UK estimate that cervical screening saves

[1] ONS Vital Statistics (2015 data) [Accessed 13.6.17] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/vitalstatisticspopulationandhealthrefrencetables]

[2] Primary Care Mortality Database, NHS Digital (2015 data). http://content.digital.nhs.uk/pcmdatabase

[3] ONS Cancer Registration Statistics, England, 2015. [Accessed 7.6.17] Available from https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/cancerregistrationstatisticscancerregistrationstatisticsengland

[4] According to the Index of Multiple Deprivation, 2015 (usually updated every five years)https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

[5] Map and data available from http://brighton-hove.communityinsight.org/#

[6] Allemani C, Weir HK, Carreira H *et al* and the CONCORD Working Group. Global surveillance of cancer survival 1995–2009: analysis of individual data for 25,676,887 patients from 279 population-based registries in 67 countries (CONCORD-2). *Lancet* 2015; 385: 977–1010. http://dx.doi.org/10.1016/S0140-6736(14)62038-9

[7] Cancer Research UK. 2017 http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers

[8] Cancer Research UK. Are all Cancer Hereditary? [Accessed on 16.8.13] Available from http://cancerhelp.cancerresearchuk.org/about-cancer/cancer-questions/are-all-cancers-hereditary

[9] Alcohol Health Alliance UK: Alcohol and cancer: knowing the risks [Accessed on 21.7.17] Available from http://12coez15v41j2cf7acjzaodh.wpengine.netdna-cdn.com/wp-content/uploads/2017/06/Alcohol_and_cancer_4pp.pdf

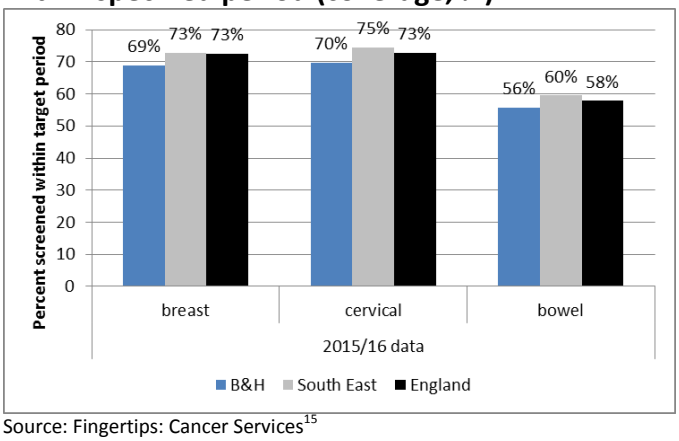
[10] Public Health England: Public Health Outcomes Framework [Accessed 5.7.17] http://www.phoutcomes.info/

[11] Parkin DM, Boyd L and Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK 2010. Br Jnl of Cancer 2011; 105 (S2), S77-81.

[12] Cancer Research UK Attributable risk - data visualisation of the results. [Accessed 16.8.13] Available from http://info.cancerresearchuk.org/cancerstats/causes/comparing-causes-of-cancer/visualisationoftheresults/

5,000 lives in England each year,[13] while breast screening saves 1,300.[14] Regular bowel cancer screening reduces the risk of dying from bowel cancer by 16%.[15] In Brighton & Hove screening rates for all of the three national screening programmes; breast, bowel & cervical cancer, are lower compared to the rates for both the South East and England (figure 1).[16]

**Figure 1 - Percentage target population screened within specified period (coverage, %)**




Source: Fingertips: Cancer Services[15]

## Key outcomes

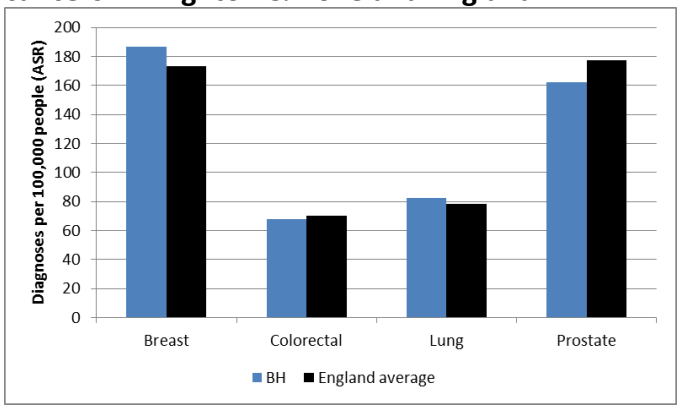
- The NHS 2017-2019 Operational Planning and Contracting Guidance[17] states that by 2020 commissioners & partners will need to be:
  - significantly improving one-year cancer survival to achieve 75% by 2020 for all cancers combined (up from 69% currently); and
  - By 2020, 95% of patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP, and 50% within 14 days.
- Increase uptake of breast, bowel and cervical cancer screening rates and to improve stage at diagnosis. [*Public Health National Profiles: Cancer Services' Indicators*][16] specifically:
  - Females aged 50-70 screened for breast cancer in last 3 years
  - Females aged 25-64 attending cervical screening within last 5 years
  - Persons aged 60-74 screened for bowel cancer in last 2.5 years
- In addition Brighton & Hove CCG & Brighton & Hove City Council are producing a Cancer Strategy for the City in 2017 (this will be posted on line when completed).

## Impact in Brighton & Hove

**Incidence**

There were around 1,100 new cancer diagnoses in Brighton & Hove CCG in 2014, equivalent to 640 new cancer diagnoses per 100,000 people (standardised rate), which is similar to the England average (608 per 100,000 people). Over half of these were for the four main cancers; breast, prostate, lung and colorectal. The age standardised rates, per 100,000 population (as shown in figure 2) for breast cancer in the City were 186.51 (similar to the England average of 173.38), colorectal 67.98 (similar to the England average of 70.43), lung 82.22 (similar to the England average of 78.34) and prostate 162.29 (similar to the England average of 177.6).[18]

**Figure 2 – Incidence rates for the four main cancers in Brighton & Hove and England.**




[13] PHE Screening update October 2015 https://cpdscreening.phe.org.uk/getdata.php?id=14456

[14] The Independent UK Panel on Breast Cancer Screening. The Benefits and Harms of Breast Cancer Screening: An Independent Review. A report jointly commissioned by Cancer Research UK and the Department of Health (England). October 2012.

[15] Cochrane Database of Systematic Reviews, 2006. Screening for colorectal cancer using the faecal occult blood test: an update.

[16] Public Health England: Fingertips Cancer Services Profile [Accessed 5.7.17] https://fingertips.phe.org.uk/profile/cancerservices

[17] The 2017-2019 NHS Operational Planning and Contracting Guidance https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

[18] Public Health England: Cancer Taskforce Dashboard [Accessed 13.6.17] https://www.cancerdata.nhs.uk/dashboard#?tab=Overview

Incidence rates have also been rising in Brighton & Hove in line with the increasing England rate.[16] Trend data suggests that the incidence for all cancers combined is increasing nationally, however this is more apparent in females than males[19].
At a national and regional level the incidence of female breast cancer is increasing (between 1995 and 2015) whereas incidence of colorectal cancer is relatively stable in both males and females. The incidence of prostate cancer is increasing, likely due to increase in identification as more men have Prostate Specific Antigen (PSA) testing, and lung cancer is decreasing in males but increasing in females (between 1995 and 2015).[20]

Between 2001 and 2014, incidence of prostate cancer in Brighton & Hove showed a clear increase, as explained above, whereas incidence of breast, lung and colorectal cancer has remained relatively stable.[18]

**Other cancers**
The incidence (directly standardised) rate of alcohol-related cancer in Brighton & Hove (2013-15) was 40.63 per 100,000 persons (42.03 for females and 39.61 for males). This was similar to the South East region at 37.16 and the England average of 38.03.[21]

The incidence (directly standardised) rate (2010 to 2012) of malignant melanoma was 27.4 per 100,000 all ages. This is significantly worse than the England average of 23.3. The South East region rate is 27.9. Brighton & Hove is the fourth worst when compared against its fifteen CIPFA[22] nearest neighbours.[23]

The rate of oral cancer registrations in Brighton & Hove was 17.6 per 100,000 (DSR) in 2013-15. This is significantly worse than the England average of 14.5 and has been since 2007-2009. Brighton & Hove ranks 121st worst out of 150 local authorities in England & Wales.[24]

As cancer treatments and survival improves, there has been a growing interest in recurrence of disease. In July 2016, the National Cancer Registration and Analysis Service (NCRAS) released new recurrence data for 2014 by Trust. Brighton & Hove NHS Trust ranked 117 out of 148 NHS trusts for cancer recurrence with a 5.6% recurrence rate compared to the lowest for The Whittington Hospital Trust at 0.7%.[25] Additional local data should be available on cancer recurrence in the future.

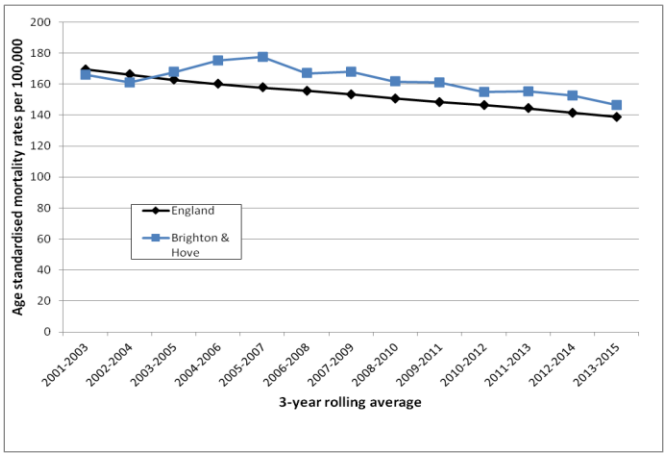
## Mortality

In 2015 cancer was responsible for 28% of all deaths (597 deaths) in Brighton & Hove and was the main cause of death in the City, 2% higher than deaths from circulatory disease.[1] Cancer was also responsible for 40% of the deaths in under-75 year olds. Lung cancer was responsible for 19% of all cancer deaths in 2015 as it is both a common cancer and has poor survival rates (due to late diagnosis in more than two-thirds of people). Lung cancer was also the cause of nearly a quarter (23%) of cancer deaths in the under 75s in 2015.[2]

**Premature mortality:** The age standardised mortality rate from cancer for people aged under 75 years is higher in Brighton & Hove (146 per 100,000) than in England (139).[10] Since 2003-2005 figure 3 shows that Brighton & Hove has been above the England average (and is also consistently higher than Sussex Cancer Network rates).

**Figure 3: Cancer mortality – age standardised for under 75s**

[19] http://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence#heading-Zero [accessed 24.5.17]
[20] ONS Statistical Bulletin on Cancer Registration Statistics, England: 2015 [Accessed 13.6.17] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/cancerregistrationstatisticsengland/2015
[21] Public Health England: Public Health Outcomes Framework: Local Alcohol Profiles for England Profiles [Accessed 24.7.17] https://fingertips.phe.org.uk/profile/local-alcohol-profiles
[22] The Chartered Institute of Public Finance and Accountancy (CIPFA) nearest neighbours are similar local authorities which are identified across a set of variables measuring the "distance" between the variable values. Those local authorities which have similar variable values are the nearest neighbours. More information can be found at: http://www.phoutcomes.info/documents/Nearest_Neighbour_Methodology.docx
[23] Public Health England: Fingertips: Health Protection Profile [Accessed 5.7.17] http://fingertips.phe.org.uk/profile/health-protection
[24] Public Health England: Fingertips: Oral Health Profile [Accessed 5.7.17] https://fingertips.phe.org.uk/profile/oral-health
[25] Cancer Recurrence by trust breakdown: October 2016, New publication. [Accessed 1.6.17] http://www.ncin.org.uk/cancer_type_and_topic_specific_work/topic_specific_work/recurrence

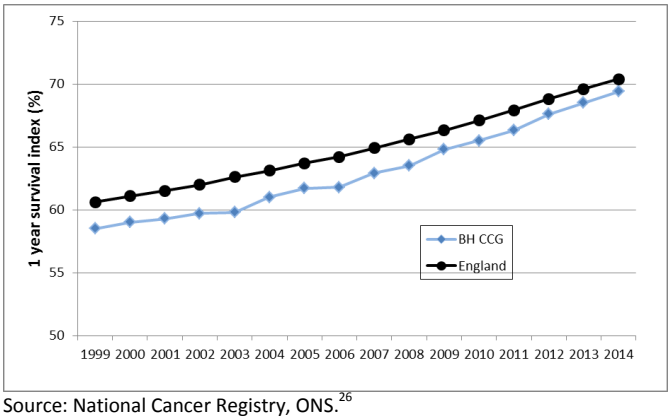



Source: Office for National Statistics, Vital Statistics data: 2015

**Survival rates**

One-year cancer survival for all tumours was 69.4% for Brighton & Hove CCG residents diagnosed in 2014 and followed up to 2015.[26] This was poorer than the England average of 70.4%. However the gap has been closing (see figure 4 of survival rates below). Amongst all cancers, survival rates for the London boroughs topped the table at 74% still living a year after diagnosis.[26]

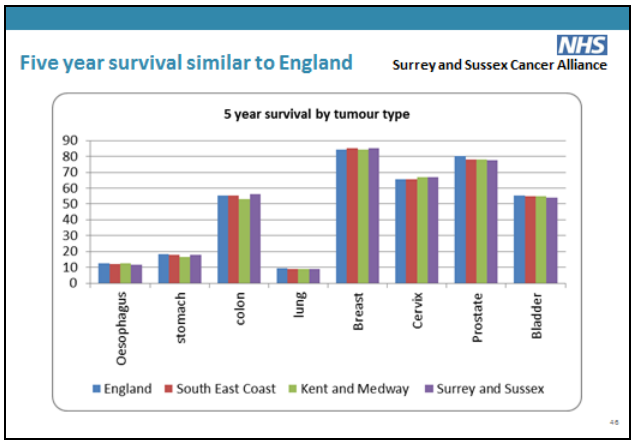
**Figure 4: One year survival index (%) for all cancers combined, by calendar year of diagnosis: all adults (15-99 years), England and Brighton & Hove CCG.**




Source: National Cancer Registry, ONS.[26]

Only 66% of Brighton & Hove CCG residents diagnosed with lung, breast or colorectal cancers live a year after diagnosis (2014 patients followed up 2015) performing comparatively worse compared to the national median of 68%.[27] There are large disparities in survival rates amongst the three main cancers in Brighton & Hove, with the 1-year survival rate for breast being 96% compared to 72% for colorectal and only 28% for lung (for adults diagnosed in 2014).[26] Currently there is a lack of data on 5 and 10-year survival rates at the CCG or local authority level. However figure 5 shows the 5 year survival by tumour type for the Surrey and Sussex Cancer Alliance.

Figure 5: Cancer mortality – age standardised for under 75s



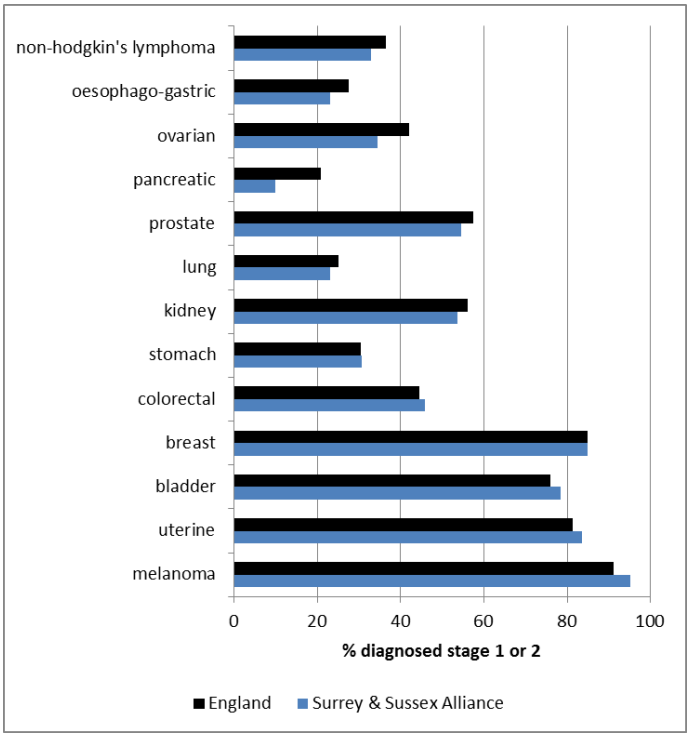

The proportion of cancers diagnosed at any early stage (1 or 2) in the city is worse than England. Rates are 50.2% for Brighton & Hove compared to 52.1% for the South East and 52.4% for England. (2015 data).[28] Figures broken down by cancer type are available for the Surrey and Sussex Cancer Alliance as shown in figure 6. In particular the Surrey and Sussex Cancer Alliance do significantly better on melanoma and uterine cancers with the proportion of patients diagnosed at stages 1 and 2 being 95.2% and 83.5% respectively. However the Surrey and Sussex Cancer Alliance do significantly worse on kidney, lung, prostate, pancreatic, ovarian, oesophago-gastric and non-hodgkin's lymphoma.

Figure 6: Proportion of patients diagnosed at stages 1 and 2, by tumour type

[26] Office for National Statistics. Index of Cancer Survival for Clinical Commissioning Groups [Accessed 13.6.17] Available from https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/cancersurvivalinenglandadultsdiagnosed/previousReleases

[27] Department of Health: Spend and Outcomes Tool (SPOT) https://www.gov.uk/government/publications/spend-and-outcome-tool-spot

[28] Public Health England: Fingertips: Health Profiles Data [Accessed 5.7.17] http://fingertips.phe.org.uk/profile/health-profiles/data



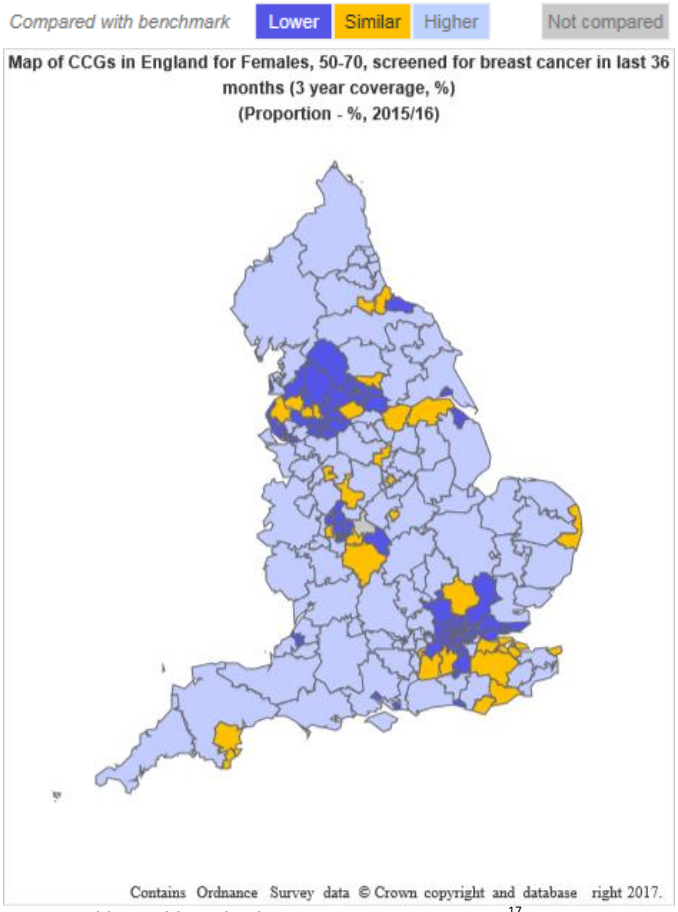

The National Cancer Diagnosis Audit (NCDA)[30] uses primary and secondary care data relating to patients diagnosed with cancer to help understand patterns of cancer diagnosis so that the impact of the referral guidelines can be assessed. For the initial report, the proportion of patients with no avoidable delay was 66.4% within NHS Brighton & Hove CCG and 64.4% for the England data (2014 data). Where the GP considered there to be an avoidable delay in the patient receiving their diagnosis, the most common reason for an avoidable delay was 'Investigation (test request and test performance)' for 20.6% of patients.[29]

## Screening rates

**Breast Cancer Screening**

In 2015/16 the proportion of women aged 50-70 who had been screened for breast cancer within the previous three years was 68.8% in Brighton & Hove CCG, lower than the England average of 72.5% and 72.9% for the South East NHS region.[15] Map 1 shows Brighton & Hove as one of the few CCGs in the south of England where coverage is significantly lower (excluding London). Brighton & Hove also performs significantly worse on breast screening and emergency presentations for cancer compared to the average for ten similar CCGs.[30]

**Map 1: Breast screening coverage English CCGs; comparison with England benchmark**



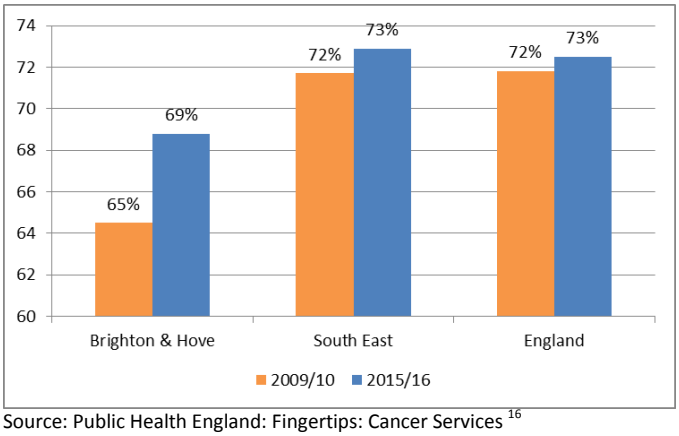

Source: Public Health England: Fingertips: Cancer Services [17]

Breast screening rates have slowly improved for Brighton & Hove and the South East between 2009/10 and 2015/16, as shown in figure 7. Women are invited to be screened every three years; for Brighton & Hove, the percentage of females, aged 50-70, screened for breast cancer in the last three years has gone from 64.5% up to 68.8% during the period 2009/10 to 2015/16. For the South East 71.7% up to 72.9% and 71.8% up to 72.5% for England, for the same period.

**Figure 7: Improvement in breast screening rates (women aged 50-70) between 2009/10 and 2015/16**

[29] National Cancer Diagnosis Audit, England (2014) – Report for Brighton & Hove CCG. http://www.cancerresearchuk.org/health-professional/early-diagnosis-activities/national-cancer-diagnosis-audit

[30] NHS RightCare Commissioning for Value Focus Pack May 2016: NHS Brighton and Hove CCG [Accessed 5.7.17] https://www.england.nhs.uk/rightcare/intel/cfv/data-packs/south/#20

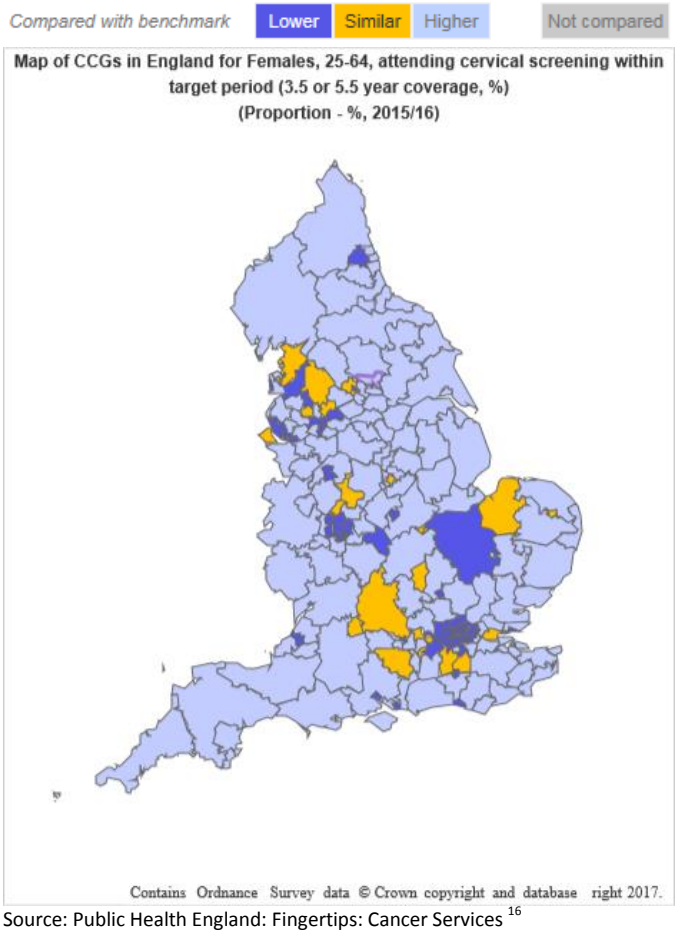



Source: Public Health England: Fingertips: Cancer Services [16]

### Cervical Cancer screening

There were 81,991 women eligible for cervical screening in Brighton and Hove in 2015/16.[16] For 2015/16, of females aged 25-64, 69.7% were screened at least once in the previous five years (coverage) which was lower than both the South East NHS regional value of 74.5% and the average for England at 72.8%.[16] Map 2 shows Brighton & Hove as one of the few CCGs areas where coverage is significantly lower (excluding London).

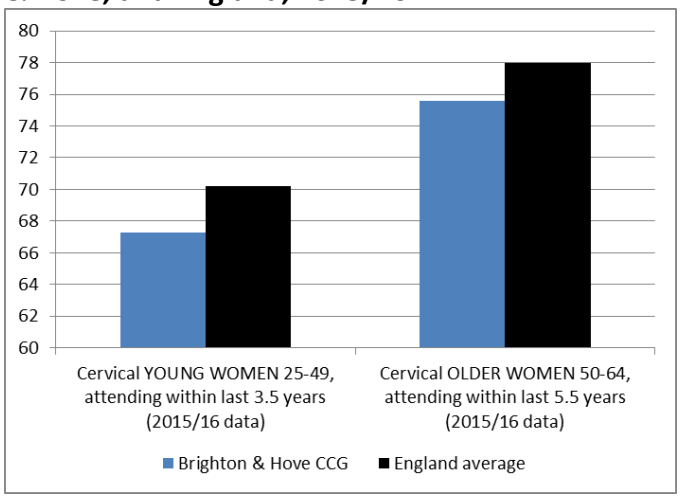
**Map 2: Cervical screening coverage English CCGs; comparison with England benchmark**




Source: Public Health England: Fingertips: Cancer Services [16]

Figure 8 shows coverage was lower for both younger (25-49 years) and older (50-64 years) women.

**Figure 8: Cervical screening coverage in Brighton & Hove, and England, 2015/16.**

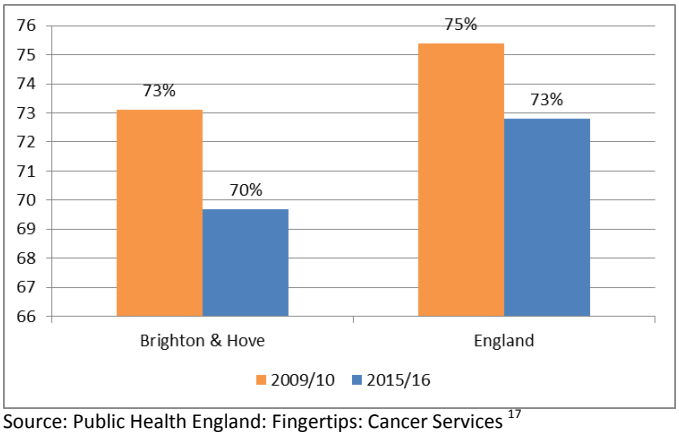



Source: Brighton & Hove CCG Screening Data Summary (Internal Report), December 2016. Original source: CRUK cancer stats.

Cervical screening rates have worsened for Brighton & Hove and England (South East regional values not known) from 2009/10 to 2015/16, as shown in figure 9. For Brighton & Hove, the percentage of females, aged 25-64, screened for cervical cancer in the last 3.5 or 5.5 years has gone from 73.1% down to 69.7%. For England the rates have gone from 75.4% down to 72.8% for England.[16] In terms of trends for the 2016/17 year, coverage levels for 25 to 64 year olds for cervical screening in Brighton & Hove decreased each quarter: 73.6% Q1 ,73.0% Q2, 72.5% Q3 and 72.2% Q4. A similar trend was seen for averages across the South; 77.3% Q1, 76.8% Q2, 76.5% Q3 and 76.3% Q4. (All five year coverage levels).[31]

**Figure 9: Decline in cervical screening rates 2009/10 to 2015/16**

[31] PHE. Cervical Screening. Quarterly KPI report. January to March 2017.

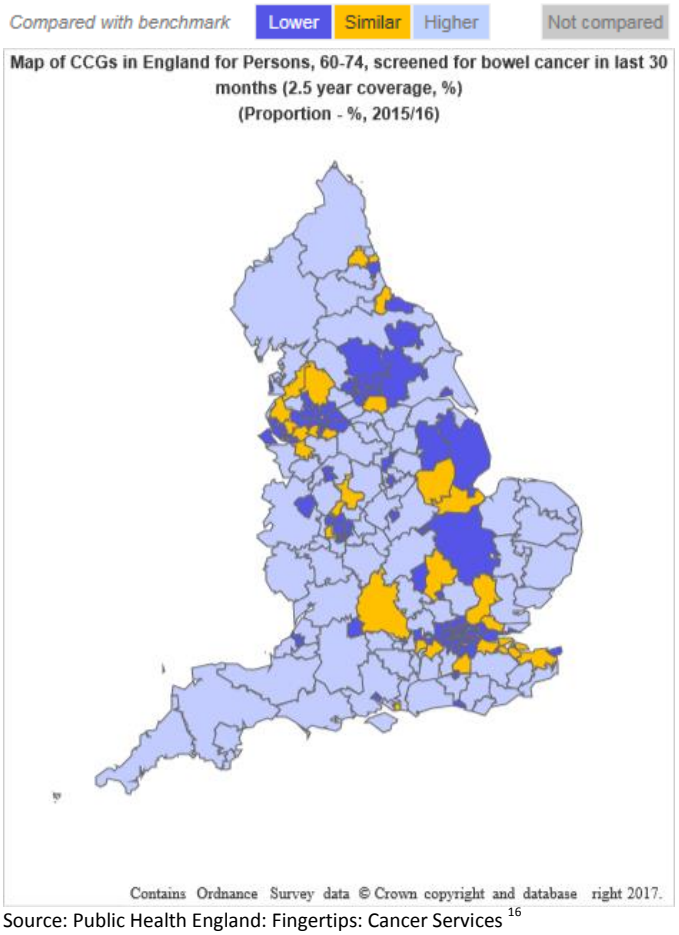



Source: Public Health England: Fingertips: Cancer Services [17]

### Bowel cancer screening

There were 31,521 people aged 60-74 eligible for bowel screening in Brighton & Hove in 2016.[16] In 2015/16 the percentage of people aged 60-74 screened for bowel cancer in the last 30 months in Brighton & Hove was 56.6%, which is lower than the South East regional value of 60.5% and the England average of 58.5%.[16] Map 3 shows Brighton & Hove as one of the few upper-tier local authority areas in the south of England where coverage is significantly lower (excluding London).

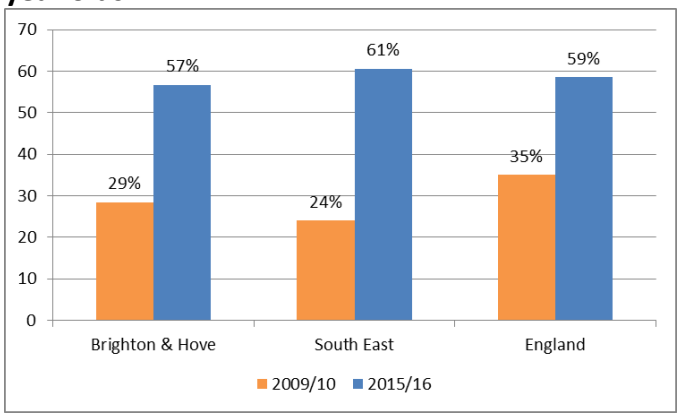
**Map 3: Bowel Cancer screening coverage English CCGs; comparison with England benchmark**




Source: Public Health England: Fingertips: Cancer Services [16]

For many years, Brighton & Hove CCG has had consistently lower rates of bowel screening compared to England (figure 10).

**Figure 10: Uptake of bowel screening for 60-69 year olds**




Source: Cancer Services Health Profile on PHOF; original data source NHS Cancer Screening Programme

Bowel screening rates have improved for Brighton & Hove, the South East and England from 2009/10 to 2015/16, with a marked increase between 2009/10 and 2011/12. For Brighton & Hove, the percentage of persons, aged 60-74, screened for bowel cancer in the last 2.5 years has gone from 28.5% up to 56.6%. For England the rates have gone from 35.0% to 58.5% for England. For the South East 24.0% to 60.5%.[16]

### Cancer Access

Brighton & Hove CCG performed poorly against the 62-day cancer waiting standard for most of 2015/16 which requires patients to have treatment by day 62 following a GP urgent referral. This was primarily due to poor performance at Brighton & Sussex University Hospital. Historically however the CCG has performed well on cancer access targets including patients being seen within 2 weeks following a referral from a GP.[32] The number of two-week wait referrals increased in 2015/16 in Brighton & Hove CCG[16] in line with the national trend and this is expected to continue.[32] In Brighton & Hove in 2009/10, there were 1,990 TWW referrals for suspected cancer (per 100,000 population). This went up to 3,366 per 100,000 population in 2015/16. This compares to 1,829 and 1,643 in the South East and England respectively in

[32] Brighton & Hove CCG Annual Report 2015/16 [Accessed 13.6.17] http://www.brightonandhoveccg.nhs.uk/sites/btnccg/files/files/Annual%20Report%20May%20Submission%20-20reviewed%2025%205%2016%20V5.pdf

2009/10 and 3,177 and 2,975 in the South East and England respectively in 2015/16.[16]

**Public voice**

In the National Cancer Patient Experience Survey results for 2016 for Brighton & Hove CCG[33], respondents rated their care with an average of 8.7 (10 being best). This was the same as the England average rating. Key findings were that:

- 75% of respondents were as involved with their care and treatment as they wanted to be (compared to 78% for England)
- 95% said that hospital staff told them who to contact if they had any worries (compared to 94% for England)
- 66% of respondents thought their GP and nurses at their general practice definitely did everything they could to support them (compared to 62% for England)
- 88% of respondents said that overall, they were treated with dignity and respect (compared to 88% for England)

In 2015 a public Cancer Awareness Measure (CAM)[34] survey[35] was carried out in Brighton & Hove to update a similar survey conducted in 2010. The Cancer Awareness Measure is a validated set of questions designed to reliably assess awareness of cancer among the general population. The survey compared the views of residents aged 45-74 living in either the two most deprived and the two least deprived quintiles in the City. Findings included:

- Residents aged 45-64 recalled significantly more cancer warning signs than those aged 65-74.
- There were clear differences in cancer awareness across the quintiles. Awareness levels for residents living in quintile 1, the most deprived, were significantly lower for all nine cancer warning signs when compared to residents living in the less deprived quintile 5.

The survey found that improvements had been made in 2015 from 2010:

- There had been a significant increase in the proportion of residents claiming they would contact their doctor about unexplained weight loss or unexplained pain.
- There had been a significant increase in residents recalling diet, family history and not doing enough exercise as risk factors for developing cancer suggesting that some of the lifestyle measures were being taken on board by people.

On the negative side there had been a significant decrease in residents recalling drinking alcohol, getting sunburnt and stress as risk factors for developing cancer.

**Spend:** Programme budgeting information shows that Brighton & Hove CCG spend on cancer decreased significantly between 2014 and 2015,from £112 spend per head of resident population in 2014 down to £45 spend per head in 2015.[27] This reflects a reduction in total cancer spend that is in line with reduction in programme spend overall. Brighton & Hove cancer spend was similar to national spend in 2015 at £49 per head (£108 in 2014), and similar to the average of those CCGs in the same deprivation decile, average £46 per head in 2015, (£107 in 2014).[27]

The cancer spend per weighted head of the population is higher than the England mean, and a higher percentage of cancer patients receiving treatment within 2 months of diagnosis. However, there are worse cancer outcomes in terms of mortality from all cancers in those under 75 years old.[36]

In 2015 spend on 'cancers and tumours' was the tenth highest area of spend for the CCG, down from fourth highest in 2011/12. Blood cancer was an area of spend which was particularly high in Brighton & Hove (outlying values compared to spend of other CCGs) at £8 per head compared to the national median of £4 per head.[27] The Commissioning for Value data atlas[37] shows that haematological cancer is the highest quartile for

[33] National Cancer Patient Experience Survey 2016, Brighton & Hove CCG, published July 2017 available at http://www.ncpes.co.uk/index.php/reports/2016-reports/local-reports-1/clinical-commissioning-groups/3366-09d-nhs-brighton-and-hove-ccg-2016-ncpes-report/file

[34] http://www.cancerresearchuk.org/health-professional/prevention-and-awareness/the-cancer-awareness-measures-cam

[35] Brighton and Hove Cancer Awareness Measure, written report; prepared by Lake Market Research for Brighton & Hove CCG, 2nd April 2015.

[36] Brighton & Hove Strategic Commissioning Intentions 2015 report

[37] http://ccgtools.england.nhs.uk/cfv2016/cancer/atlas.html

Brighton & Hove for both elective and non-elective spend (admissions per 1,000 population) and has a particularly high average length of stay after an elective admission (not including day cases) of 10 days (range for all England CCGs 3 to 15 days).

The RightCare commissioning for value pack for Brighton & Hove January 2017[38] also presents opportunities for quality improvement and spend differences comparing NHS Brighton & Hove CCG to the best five CCGs. It suggests Brighton & Hove CCG could potentially save £359,000 on primary care prescribing if performed at the average of the five similar CCGs (2015/16 data).[38] Moreover, comparing to other CCGs, the areas where Brighton & Hove are doing worse compared to their peers on cancer are:[38]

- Breast cancer screening
- % first definitive treatment within 2 months (all cancer)
- Breast cancer detected at an early stage
- Bowel cancer screening
- Lower GI cancer detected at an early stage
- Successful quitters, 16+
- Mortality all cancers all ages

In recent years Brighton & Hove has invested largely into local commissioned services and early diagnosis so these factors should improve over time.[39]

There is a commissioned programme of work with Albion in the Community to increase awareness of the signs and symptoms and cancer risk factors, and to promote screening. They use volunteers to deliver campaigns such as Be Clear on Cancer. The service focuses primarily on residents living in quintile 1 (most deprived) in order to reduce inequalities in cancer outcomes. It also works specifically with identified groups e.g. specific age, gender and BME. They also work with schools on sun safety. As one of their outcomes, Albion in the Community delivered training and presentations to just under 15,000 target individuals between July 2016 and March 2017.[40]

## Local inequalities

**Age:** Incidence increases with age for most cancers, yet older people in Brighton and Hove are not aware of their increased risk and have lower awareness of cancer symptoms than younger groups.[41]

Reduction in cancer mortality has been much less marked for the over 75s than the under 75s. There is evidence that older people's cancers are investigated and treated less intensively.[42]

**Gender:** Cancer incidence and mortality is higher in men than women but, due to women's longer life expectancy, more women than men are living with or beyond a diagnosis of cancer. Men have a lower awareness of the signs and symptoms of cancer.[35]

**Socio-economic deprivation:** Incidence and mortality from cancer is considerably higher in the more deprived groups, largely due to lifestyle factors, especially higher smoking rates. Brighton & Hove is a local authority with particularly high levels of smoking: 20.9% of the adult population smoke, compared to the England average of 16.9%. Amongst routine and manual workers, this rises to 34.2% of the adult population compared to the England average of 26.5%.[16]

There is evidence of poorer uptake of bowel and cervical cancer screening in GP practices with more deprived populations.[43] This link with deprivation is not seen in breast screening. Screening uptake rates tend to be highest in the West locality which has fewer practices with more deprived populations.[41]

[38] RightCare Commissioning for Value CCG Data Pack, Refreshed 'where to look' packs, January 2017 [Accessed 5.7.17] https://www.england.nhs.uk/rightcare/intel/cfv/data-packs/south/

[39] Brighton & Hove CCG: Cancer – New LCS Contract summary evidence and guidance. [Accessed 5.7.17] http://www.gp.brightonandhoveccg.nhs.uk/file/1130/download?token=5xs26Qkt

[40] Albion in the Community: Cancer Awareness Early Diagnosis contract review. June 2017

[41] National Cancer Intelligence Network. Evidence to March 2010 on cancer inequalities in England. June 2010. [Accessed 30.08.13] Available from http://www.ncin.org.uk/view?rid=169

[42] The Age Old Excuse: The under treatment of older cancer patients; Macmillan Cancer Support Report. [Accessed 13.6.17] http://www.macmillan.org.uk/documents/getinvolved/campaigns/ageoldexcuse/ageoldexcusereport-macmillancancersupport.pdf

[43] Internal report: Cancer screening in Brighton & Hove (Final 3.10.14)

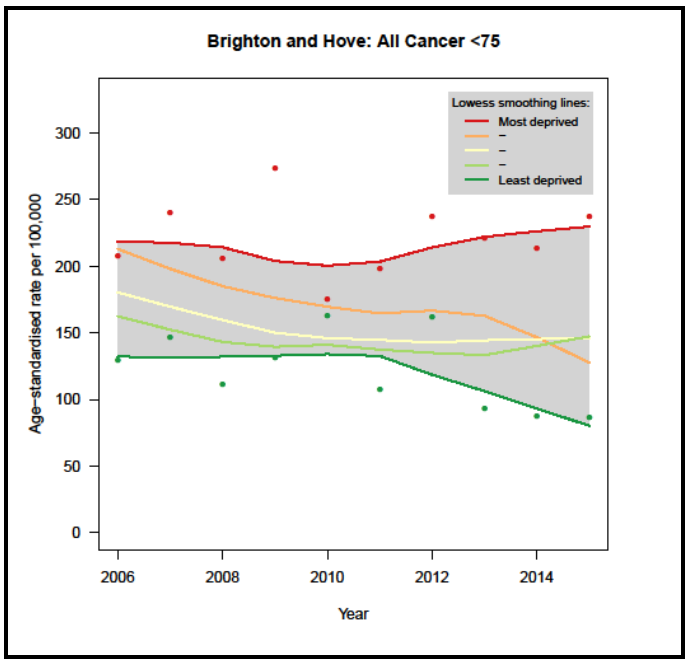
# 7.5.8 Cancer

There is a clear survival gap between the most and least deprived populations. Mortality rates from cancer are higher in the more deprived populations of Brighton & Hove and the gap between the most and least deprived quintiles for under 75s has widened since 2006 (Figure 11) with more than double the cancer death rate in the most deprived quintile compared to the least.

The local survey conducted in 2015[35] revealed that awareness of the signs and symptoms of cancer is lowest in quantile 1, the most deprived section of the community in Brighton & Hove compared to quantile 5, the least deprived. People in the most deprived quantile were also worried about what a doctor might find and would be too scared. In addition the survey showed that people in quantile 1 would be concerned about wasting a doctor's time and feel they would have difficulty talking to a doctor and not feel confident speaking about their symptoms.[35]

**Ethnicity:** Women from BME groups (including White Other) are more likely to present with more advanced breast cancers and have poorer survival than White British women.[44] Locally non-white residents were more likely to perceive barriers to help-seeking.[45]

**Figure 11: Age Standardised Mortality Rates per 100,000 population in Brighton & Hove, by quintile of deprivation.**




Source: ONS Annual Mortality Extracts, 2006-2015

**Sexuality:** Differences in health-related behaviours among lesbian, gay, bisexual and transgender (LGBT) people may lead to differences in cancer incidence. Perceptions of risk and healthcare seeking behaviour may also vary.[35] In 2012, a survey of 152 people from the LGBT community was carried out to investigate health and inclusion.[46] In terms of cancer screening, a high percentage of LBQ women were not having smears at regular intervals although this can be said to be true of the Brighton & Hove screening population generally. Some individuals had been wrongly informed that they were not at risk because of their sexuality. Levels of discrimination encountered by LBQ women in cancer screening services are generally low, however those incidences which do occur around cervical screening can be very traumatic and upsetting.[46]

**Disability:** There is limited national information on variations in cancer incidence, treatment and outcomes for people with a disability. People with learning disabilities appear to have a similar age standardised incidence rate for all cancers combined but incidence by tumour site may be different. There is some evidence for increased cancer incidence associated with some mental illnesses, which is associated with increased cancer mortality.[35] A recent report found that eligible

[44] Cancer Inequalities in the South East Region: The Burden of Cancer http://www.sepho.org.uk/Download/Public/10398/1/cancerIneq1_051006_FINAL.pdf

[45] Lake Market Research. Cancer Awareness and Early Diagnosis Initiative CAM Final Results. NHS Brighton and Hove: April 2010.

[46] LGBT Health and Inclusion Project: Lesbian, Bisexual and Queer Women's Health Survey – Report (2012)

females without learning disabilities were more likely to receive breast cancer screening than eligible patients with learning disabilities.[47]

**Religion:** No local or national information available.

**Predicted future need**
The Surrey & Sussex Cancer Alliance is made up of clinical leaders and patients. It focuses on providing improvement in early diagnosis, the recovery package and the development of stratified pathways.

A key focus of the Alliance is identifying cancer earlier, speeding up and improving diagnosis, increase current capacity and to open new Rapid Diagnostic and Assessment Centres.[48]

The incidence of some cancers is increasing - for instance, lung cancer and upper gastrointestinal cancer in females, likely to be related to lifestyle factors such as smoking, diet and alcohol intake. Thus improving people's lifestyle choice's needs to remain a priority.

Cancer survival is lower in more deprived populations hence there is a particular need to focus on reducing the inequalities gap.

### What we don't know
We need a better understanding of where outcomes could be improved for cancers other than the main four. Work is also to be conducted to ascertain why screening rates are so low for cancer in the City and whether there are significant differences for any particular groups of the population.

Since people are live longer after a diagnosis of cancer, then we should aim to have a better understanding of the ongoing health needs of cancer survivors.

## Key evidence and policy

***National Policy***
The Independent Cancer Taskforce has produced a strategy; 'Achieving World Class Outcomes for Cancer 2015-2020; A Strategy for England'[49] which provides a transformational framework for the diagnosis, treatment and care for people affected by cancer and works towards delivering a gold standard service.

The 2017-2019 NHS Operational Planning and Contracting Guidance[17] as mentioned in the Key Outcomes section above.

The 2014 NHS Five Year Forward View[50] which sets clear direction for the NHS, highlighting why change is needed and what it will look like. It states action needs to happen in three areas: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer.

And more recently in 2017 the 'Next Steps of the NHS Five Year Forward View'[48] highlights that identifying cancer earlier is critical to saving more lives which requires the need to speed up and improve diagnosis, increase current capacity and open new Rapid Diagnostic and Assessment Centres.

The National Institute for Health and Care Excellence (NICE) has produced guidance in relation to suspected cancer referral & recognition, Guidance 12 (NG12).[51] The implementation of this is the responsibility of local NHS commissioners and providers. In response partners have produced a joint implementation plan for Brighton and Sussex University Hospital.

**Local Policy**
The Brighton & Hove Health & Wellbeing Board is a partnership group to improve the health & wellbeing of local people. It produces a local Joint Health & Wellbeing Strategy, stating how the health & wellbeing of the local population will be

[47] Public Health England: Learning Disabilities Health and Care: The New Information Source, presented at the South East Public Health Information Group, June 2017
[48] Next Steps of the Five Year Forward View (2017) https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
[49] Achieving Word Class Outcomes for Cancer 2015-2020 A Strategy for England; Independent Cancer Taskforce Review (2015) http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf
[50] Five Year Forward View (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[51] NICE guidance. 2015. Suspected cancer referral & recognition, Guidance 12, NG12. https://www.nice.org.uk/guidance/NG12

improved. The most recent was produced in 2015.[52] It contains the target of 'Increase the uptake of health checks and cancer screening'.
In addition in 2016 Brighton and Hove became part of three larger geographical footprints in order to develop and commission new models of care.

These are:
Sussex and East Surrey Sustainability and Transformation Partnership
Central Sussex and East Surrey Alliance Place Based Plan (CSESA) and
Surrey and Sussex Cancer Alliance.

The aims of these partnerships is to build on local plans over a wider geographical area, for neighbouring CCGs, local authorities and NHS providers to work together to provide a joined-up approach to provide better more efficient services. Cancer is detailed as an area of focus which can deliver the greatest public health and wellbeing improvements, based on current deaths, years of life lost, healthcare costs and health inequalities across the Sussex and East Surrey footprint population.

Caring Together[53] is a new programme of work that builds on work that is already underway in Brighton & Hove to improve local health and social care for people living in our city. It supports the wider aims to transform health and care services across Sussex and will help us respond to the rising demand on services with the resources we have available and builds on the work already being undertaken in the city.

The Caring Together plan is aligned to the Sustainability and Transformation Plan (STP), which covers the wider area of Sussex and East Surrey. Caring Together is Brighton & Hove's contribution to the STP.

For 2017 to cover the period 2017-2020 the Brighton & Hove City Cancer Strategy is being produced in conjunction with the local Cancer Action Group. The group's vision is to improve outcomes for cancer patients in Brighton & Hove and improve the experience of those affected by cancer. The strategy details how this will be achieved. It will be published on the Brighton & Hove CCG and Brighton & Hove City Council websites September 2017.

**Evidence**
NHS England and Public Health England have launched a new online dashboard of cancer-related information to support CCGs and providers, which brings together data from across patient pathways into one, easy-to-use portal.[18] The aim is to show comparative performance across the country at CCG and provider level using metrics like one-year survival, cancer patient experience and the number of cancers diagnosed through emergency presentation, to help reduce variation and improve services. The dashboard was developed in response to a recommendation of the Independent Cancer Taskforce and was launched alongside the NHS cancer strategy implementation plan.

### Recommended future local priorities
In March 2017 the Surrey & Sussex Cancer Alliance launched its delivery plan. It sets out the specific vision, goals and objectives of the Alliance in light of the national and local context it operates within.

To meet the priorities as set out in the forthcoming 2017 Brighton & Hove Cancer Strategy. These are prevention, early diagnosis, prompt high quality treatment and survivorship.

### Key links to other sections
- Smoking
- Healthy weight
- Alcohol
- Physical activity and sport
- Sexual health

### Further information
National Cancer Intelligence Network.
http://www.ncin.org.uk/home
Cancer Research UK Local Cancer Profiles: Brighton & Hove Clinical Commissioning Group
http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/?location-name-

[52] Brighton & Hove Joint Health & Wellbeing Strategy. 2015. Brighton & Hove Health & Wellbeing Board. https://present.brighton-hove.gov.uk/Published/C00000826/M00005746/AI00049010/$20151204150751_008319_0034662_AppendixoneJHWS.docA.ps.pdf
[53] Caring Together: Brighton & Hove CCG; Brighton & Hove City Council & partners.
http://www.brightonandhoveccg.nhs.uk/search/site/Caring%20together

1=NHS%20Brighton%20&%20Hove%20CCG&location-1=09D
Cancer Inequalities in the South East Region: The Burden of Cancer
http://www.sepho.org.uk/Download/Public/10398/1/cancerIneq1_051006_FINAL.pdf
2017-2019 NHS Operational Planning and Contracting Guidance
https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

**Last updated**
July 2017

*Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.*

## 1. Breastfeeding Report Update

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 12th September 2017

1.3 Author of the Paper and contact details:
**Kerry Clarke,** Children,
Young People and Public Health Schools Programme Commissioner,
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Kerry.Clarke@brighton-hove.gov.uk

And

**Siobhan Hier,** Head of Healthy Child Programme, Brighton & Hove Sussex Community NHS Foundation Trust, Brighton General Hospital, Elm Grove, Brighton. BN2 3EW. siobhanhier@nhs.net

## 2. Summary

2.1. This report provides the Health and Wellbeing Board with an update on breastfeeding across the city, set within the context of the new Public Health Community Nursing (PHCN) contract. The report aims to provide assurance to the board of the city's approach to breastfeeding following questions raised by the public at the 13th June 2017 meeting.

2.2. The PHCN service details confirm both the priority given to maintaining breastfeeding as a key health impact area, which is performing significantly above England averages, and confirm to the board the breadth of outcomes the PHCN contract will be aiming to achieve.

2.3. Detail is provided below to demonstrate that the needs of the population and evidence based practice inform how Sussex Community NHS Foundation Trust (SCFT) target delivery across all outcomes. For breastfeeding that includes high need groups such as under 20's and localities with high need.

2.4. The new delivery model builds on the skills and expertise that exists within the workforce and has been informed by the learning over the recent years from the breastfeeding team. There is a range of interventions available to parents to support breastfeeding and expertise within the team to oversee ongoing developments.

2.5. The council's public health commissioners and SCFT are working together to ensure that during the transitional period, when the changes to the new integrated service are being embedded and learning from training is being implemented, families across the city will continue to have access to a strong approach to support them to make the choice to breastfeed their babies. The delivery model will enable the contacts and relationships with the PHCN teams to connect across the wider health outcome areas.

## 3. Decisions, recommendations and any options

3.1 That the Health and Wellbeing Board note the report.

3.2 That the Board agrees that if further information is required concerning the contract and its delivery this is directed to HOSC

## 4. Relevant information

4.1. This report provides the Health and Wellbeing Board with an update on breastfeeding across the city, set within the context of the new Public Health Community Nursing Contract.

4.2. The Public Health Community Nursing Services, Children and Young People aged 0-19 contract was awarded to Sussex Community NHS Foundation Trust (SCFT) following the approval of the Health and Wellbeing Board on 22 November 2016.

4.3. The summary of the timeline and reports attached to the Public Health Community Nursing Services Contract are as follows:

| **Summary of reports to HWB** | |
|---|---|
| **Report Title and date** | **Decision & Outcome** |
| Public Health Nursing Commissioning Strategy (PHNCS) 15th March 2016 | The Director of Public Health was granted delegated authority to place a Prior Information Notice and to carry out a competitive procurement process if alternative providers came forward |

| | |
|---|---|
| PHNCS 22nd November 2016 | The Health and Wellbeing Board accepted the recommendation that the Public Health Community Nursing Services, Children and Young People aged 0-19 contract be awarded to Sussex Community NHS Foundation Trust (SCFT) |

4.4. The aim of the Public Health Community Nursing (PHCN) Service for Children and Young People aged 0-19 is to help empower parents and young people to make decisions that affect their own or their family's health and wellbeing.

4.5. The role of the service is central to improving the health outcomes of children and young people, and to reducing inequalities. In place now is a single integrated service from pregnancy to adulthood, covering all stages of childhood. It will provide a universal service to every child and family and has the ability to identify children at risk of poor outcomes and provide early support and help or referral to appropriate services for families in need of additional support.

4.6. The PHCN service has four levels of support offering every family a programme of screening tests, developmental reviews and information and guidance on parenting and healthy choices. The role of the PHCN service in child protection and safeguarding children is an essential component of the service and is a priority at every level of the service.

4.7. The Healthy Child Programme builds on the unique, universal and non-stigmatising service that health visitors provide to all families with children under five. They develop trusting relationships that support families, provide clear leadership roles across skill mix teams and have strong connections with partners working across early years to ensure access to appropriate support. The contract is set up to focus on what is achieved across six high impact areas in the 0-5 age range.

4.8. The High impact areas are:

- parent and early years
- maternal mental health
- **breastfeeding**
- healthy weight
- minor illnesses and accidents
- ready for school

4.9. The benefits considered for breastfeeding include destigmatising breastfeeding and making the connections across health areas such as between breastfeeding and emotional wellbeing.

4.10. The council's public health commissioners have set out the outcomes and key performance indicators in the service specification with SCFT, and included a requirement that the PHCN workforce is led by Health

Visitors and School Nurses, some with specialist lead roles, and supported by skill-mixed teams drawing on a range of expertise to ensure that services are age appropriate. It does not set out the staffing structures to achieve the specified outcomes. It is for SCFT to determine how best to achieve the outcomes within the financial envelope of the contract.

4.11. In the new contract the following has been agreed:

**Outcome:** More babies are fed breast milk

**Key Performance Indicator:** 72% of infants will be breastfeeding at 6 – 8 week review for year end 2017/18.

**Monitoring Activity:** 95% of records for infants will have the breastfeeding status recorded.

4.12. Two main sources of information were used to set the health outcomes across the contract.

- **National Public Health released information:** Brighton and Hove Child Health Profile 2017 has been used as the baseline year. This provides a snap shot of child health and shows how children's health and wellbeing compares with the rest of England across 32 different measures. It also enables the identification of areas performing well and from whom we may be able to learn. (see appendix 1 for full details)

- Brighton & Hove has 12 green indicators where the performance is significantly better than the England average, 15 amber indicators which are not significantly different to the England average and 5 red indicators which are significantly worse than the England average but not related to breastfeeding. (see appendix 2 for summary of PHCN response to red rated health indicators)

    - The Child Health profile confirms that for the two breastfeeding measures Brighton & Hove is significantly above the England average. This starting point is an outstanding positive for Brighton & Hove as breastfeeding is one of the most important contributors to infant health. It provides benefits for an infant's growth, immunity and development.

- **The Maternal and Infant Health Joint Strategic Needs Assessments (**September 2016) confirm the trends and areas for targeting inequality.

    - The percentage of local mothers who breastfeed their babies in the first 48 hours after delivery increased from 85% in 2010/ 11 to 88% in 2014/15, against the static England figure of 74% in 2010/11 to 2014/15 and SE figure of 78% in 2010/11 to 2014/15.

- In 2015/16 the percentage of infants who were totally or partially breastfed at 6-8 weeks was 71.5% and for two quarters Brighton & Hove had the highest proportion of infants (57%) exclusively breastfed at 6-8 weeks in England.

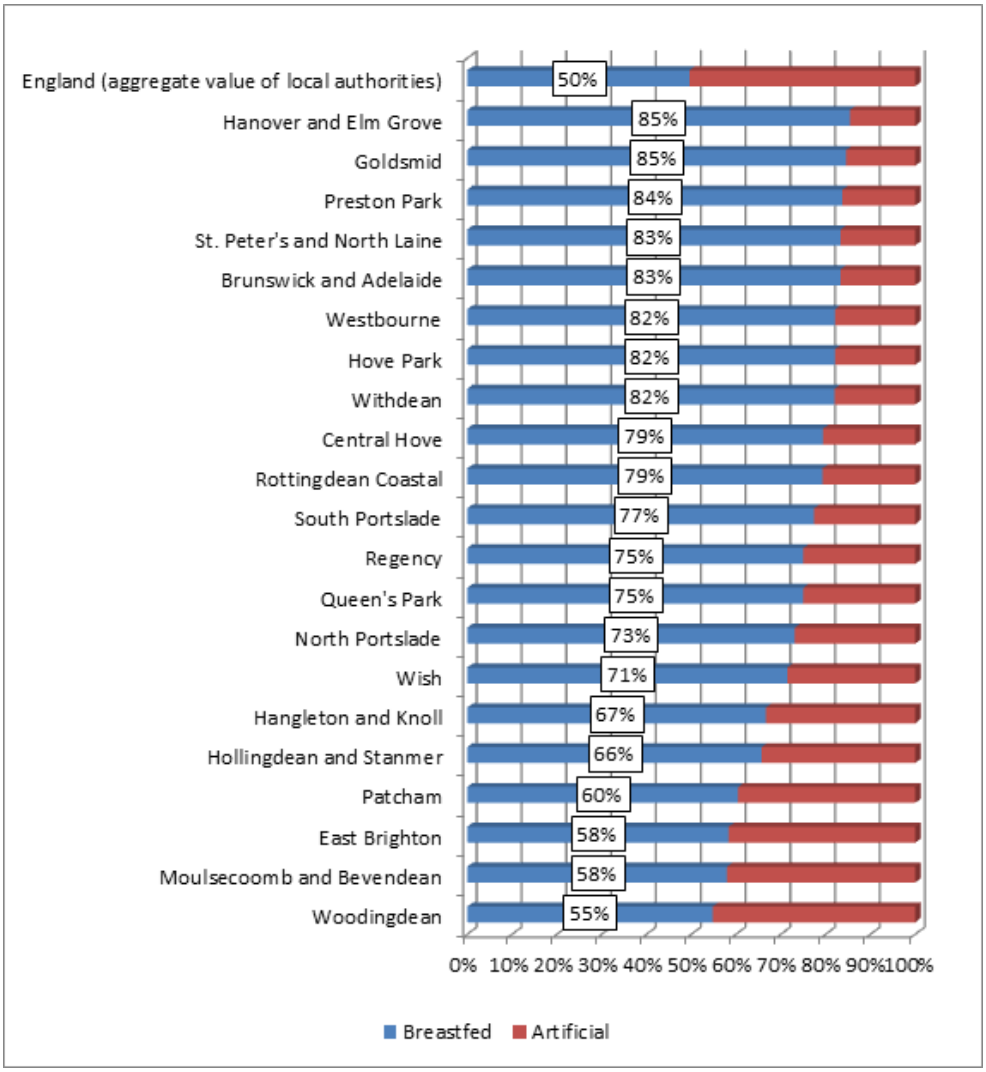
- In 2016 breastfeeding rates were generally lowest in the East area of the city and highest in the Central area (see Figure 1 below for ward level data).

- The breastfeeding prevalence for 2016 in the 20% most deprived areas of the city was 55%. This was still considerably higher than the England average of 43%.

- The youngest mothers (<20 years) are least likely to initiate breastfeeding (68%). There is a clear age gradient with breastfeeding rates increasing with maternal age up to a rate of 95% among mothers aged 35 years or over. There has been little change in this pattern over time.

- As regards ethnicity and breastfeeding initiation the highest prevalence is among White other mothers (96%) and Black African mothers (98%) who have significantly higher rates. White Irish (80%), White British (86%) and Mixed White and Black Caribbean mothers (83%) have the lowest rates. A local study of breastfeeding practices amongst Gypsies and Travellers found that New and Welsh Travellers were more likely to breastfeed compared to Gypsy or Irish Travellers. Barriers to breastfeeding identified included embarrassment, lack of privacy, no family tradition of breastfeeding and the convenience of bottle feeding.

**Figure 1: 6-8 week breastfeeding rates by ward, Brighton & Hove Jan-Mar 2016 and for England (based on infants with known breastfeeding status).**




**Source:** Patient Information Management System, Sussex Community NHS Trust

4.13. The new PHCN Service contract started in April 2017 and will deliver the Healthy Child Programme (HCP). The targets agreed are informed by the above intelligence which SCFT used to develop their offer and as they are refreshed, will also be used to monitor impact.

4.14. The PHCN service is a progressive universal service offered to all and provides the 5 mandated contacts; Ante natal, New Birth, 6-8 weeks, 9-12 months and 27 months, which include several opportunities to promote breastfeeding and to build/increase the confidence of mothers and fathers to choose breastfeeding and continue to breastfeed.

4.15. The contracted PHCN service is being delivered with a significantly reduced financial envelope. SCFT have looked at how to ensure they continue to offer a highly skilled service. This is within the context of having a skilled nurse led service that will receive additional training, provide new birth visits and promote access to breastfeeding support drop-ins. The changes to functions provided by HVs will be monitored to ensure the breastfeeding outcomes are achieved.

4.16. SCFT have embedded the role of the peer supported volunteers within the hospital to engage with parents at a key breastfeeding decision making time and have strong relationships to signpost parents to voluntary sector partners.

4.17. SCFT has a specialist breast feeding coordinator and a peer support post that provide a resource across the service to equip frontline health visitors and children centre staff, as well as providing direct services to families and volunteers as described in 4.26

4.18. SCFT has a highly trained health visitor workforce who are updated regularly and plans are in place to enhance the skills of all levels of staff to be able to target evidenced based breast-feeding interventions across the city, in particular in those areas where breast feeding uptake is lower. This includes the band 4 posts, Healthy Child Practitioner – Nursery Nurse posts. SCFT has increased the number of these posts from 8.6 whole time equivalent (wte) to 13 wte in order to support the delivery of the whole of the Healthy Child programme. SCFT are in a position to enhance the resource in those areas where the breastfeeding prevalence is lower i.e. Woodingdean, East Brighton, Moulsecoomb and Bevendean by giving additional training to staff working in these areas in order to increase the breastfeeding prevalence.

4.19. The revised staffing structure has resulted in the removal of the specialist nursery nurse who has been redeployed into a post within the same children's centre.

4.20. Health visitors offer a home visit to all parents antenatally, also a new birth visit and at 6-8 weeks. This provides ideal opportunities for breastfeeding support and promotion. If feeding issues arise at any time health visitors write a breastfeeding action plan with the parents and offer additional support as necessary. Most of the support and promotion of breastfeeding is carried out in the community by health visitors. It can involve signposting as well as direct work. SCFT has committed to training all health visitors in an evidence based programme called Promotional Guides, which strengthens their relationship and engagement skills. It will also support families to build on their confidence and knowledge to empower them to make healthy choices about themselves and their children.

4.21. Another important issue that can potentially impact on breastfeeding is the connection between breastfeeding and emotional health. SCFT recognises the importance of identifying and treating postnatal depression, of good mental health and a healthy attachment between mothers and their babies. In response SCFT has recruited a specialist perinatal mental health practitioner (health visitor) to work across the city. This post will ensure a high level of expertise in the health visiting

service and knowledge about local services and access to effective interventions and support.

4.22. In order to provide additional support to families with higher levels of need as identified in the Maternal and Infant Health Joint Strategic Needs Assessment, SCFT are developing a 'Healthy Futures' team. This team will work with all teenage parents in the city including younger mothers who generally have the lowest uptake of breastfeeding. Other groups the team will work with include: parents with a history of children being looked after and not already known to the service, refugees, asylum seekers, travellers and those in emergency housing, children registered as home educated; children missing education or educated other than at school; children excluded from school and within the Pupil Referral Unit; children who are registered as young carers and not in local authority education. With the focus on the antenatal period, SCFT will have the opportunity to intervene early for these new families and support them in their decision making.

4.23. During the transition to the new service, SCFT will look at how the Healthy Futures Team can work collaboratively with the Healthy Child Programme teams and specialist services to support breastfeeding across all areas of the city, particularly in those areas where there is a clear inequality gap in prevalence and duration rates, and to increase community capacity. One of the health visitors in the Healthy Futures team has the lactation consultant qualification.

4.24. The service will be enhanced in many service areas with the proven value of peer to peer support volunteers. The peer supporters commit to a minimum of 2 hours a week for 6 months but several have been working for much longer than this. They are not used to replace paid workers but are asked to work where they can enhance the service to mothers. A number have gone on to work in maternity units and related fields.

4.25. Each year the SCFT Breastfeeding Peer Support coordinator trains about 20 peer supporters. There are up to 30 active peer supporters at any one time, mostly on the postnatal ward. SCFT's ambition is to increase peer support within community groups and to ensure that all work with volunteers complies with the Volunteer Policy which states that volunteers cannot be used to replace paid staff.

4.26. In summary the operational plan for the breastfeeding team will include:

- Continuing with the peer support programme, with an emphasis on community groups where possible.
- Ensure continuing breastfeeding expertise within the Healthy Futures Team
- Continue additional teaching in areas of the city where breastfeeding rates are lower.

- Additional teaching for a Breastfeeding Champion Network – there is a plan for one in each team
- Continue to explore managing the specialist offer for the team e.g. early phone calls in areas where breast feeding is lower
- Continue close operational working with local partners e.g. La Leche League are running a drop-in at Roundabout ( Whitehawk ) Children's Centre.

4.27. Re-launch the breastfeeding steering group with partners across the city to ensure continued high profile for this area of public health and a coordinated offer for families. Key to the success of the child health programme will be how the council's public health commissioners and SCFT work together to monitor and understand the impact of the whole PHCN contract. The framework has been set up to measure, on a quarterly basis, the contribution the service makes to improve health outcomes. Public Health and SCFT will carry out more in depth analysis of the intelligence to look more closely and timely at inequality issues. To date, the most up to date position is Q4 2016/17.

4.28. **Present position: Nationally**

The Breastfeeding prevalence at 6-8 weeks after birth for the latest available quarter was released in July 2017. The position was:

| Local Authority | Q3 2016/17 | Q4 2016/17 |
|---|---|---|
| Brighton and Hove | 69.0% | 67%* |
| England (aggregate value of local authorities) | 44.3% | 44.3% |

*Brighton and Hove Q4 figure failed the national quality validation. The requirement is that 95% of the records must have the breastfeeding status recorded to meet the required quality check. In Brighton & Hove, 93.5% of records had a recorded status, so with that caveat, the rate was 67%

This figure is based on the number of babies' being breastfed as a percentage of the total population of babies who are 6 – 8 weeks within the time period.

4.29. **Present position: Local information.**

The target was set at 72% of infants receiving a 6 – 8 week review being breastfed at 6 – 8 weeks and the performance was as follows:

| | Q1 2016/17 | Q2 2016/17 | Q3 2016/17 | Q4 2016/17 |
|---|---|---|---|---|
| Brighton and Hove | 69.4 | 71.6 | 72.1 | 71.8 |

The reason this figure produced locally is different to the national figure is because it was based on the % of babies' breastfed of those who received a 6 – 8 week review within this time period.

4.30. The PHCN performance framework consists of a comprehensive set of measures for the entire 0 – 19 service, as outlined in appendix 3. In the contract, the target for breastfeeding is 72% of all babies, measured at the 6 – 8 week review. So whilst the target of 72% remains, this will mean an actual performance increase from 69% (validated Q3 figure) to 72% based on the nationally reported data.

4.31. The ongoing delivery will be monitored in the following ways with service improvement actions identified and agreed as and where further improvements are required.

- Quarterly performance reviews: Public Health and SCFT will review performance across all the KPIs. New to the previous arrangements will be the ability to demonstrate the percentages of cohorts not meeting the agreed threshold levels and the achievement of the outcomes against specific interventions.

- Key to the success of any service is how the service user experiences and shapes the service. Annual service user feedback will be completed and used to shape service delivery.

- Data will be matched against the intelligence gained from the National Child Health Profiles and local JSNAs to inform service improvement.

4.32. The detail in this report is attached to the contract held by Public Health with SCFT. However breastfeeding starts with achievements from Brighton and Sussex Universal Hospitals.

4.33. BSUH is part of the UNICEF Baby Friendly Initiative which provides the evidence based standards for their service. All staff are trained and educated according to their role to support and care for mothers and their families, the Infant Feeding Protocol is reviewed and implemented following national standards and there is a named Infant Feeding Midwife lead for the Trust.

4.34. All women have the opportunity to have meaningful conversations, both during pregnancy and the early days postnatally regarding feeding their babies. First time mothers are invited to antenatal classes where breastfeeding is explored. All women, where possible are encouraged to hold their babies in skin to skin after birth and continue for as long as they wish. Midwives, Maternity Support Workers and Maternity Care Assistants are all trained to offer evidence based breastfeeding support. All women are shown how to hand express and given information about maintaining and assessing adequate milk supply. When home, women have visits by the Community Midwives and

Maternity Support workers and women are also given information about local breastfeeding drop-ins, including the BSUH drop in at the Princess Royal Hospital.

4.35. In addition, the Trust provides the following breastfeeding support:

- **Tongue-tie assessment and frenulotomy clinics**
- **Breastfeeding drop-in**

4.36. In 2014/15 Brighton and Hove breastfeeding initiation was 87.9% significantly above the England position of 74.3% In April 2017, local provisional data indicates that 85% of babies born had breastfeeding initiated reported on their records.

## 5. Important considerations and implications

**Legal:**

5.1 This report is provided for information only. There are no legal implications.

Lawyer consulted: Judith Fisher Date:29.08.2017

**Finance:**

5.2 The Breastfeeding programme sits within the Community Nursing 0-19 contract which is funded by the Public Health Grant and the Brighton and Hove CCG. The total value of the contract is £14.27M over the 3 years (£4.750M for 17-18, £4.745M for 18-19 and an agreed uplift to £4.774M in 19-20). The contract outlined in this report is within the allocated budget.

Finance Officer consulted: Sophie Warburton Date: 31:08:2017

**Equalities:**

5.3 The Public Health Community Nursing Service universal services are delivered with a scale of intensity proportionate to the level of needs experienced by certain population groups including those arising from their protected characteristics. These considerations are integral to the services delivery achievements and ability to narrow the inequality gap. The performance arrangements use a selection of intelligence approaches to ensure that service improvement actions can be addressed on a quarterly or annual basis.

**Sustainability:**

5.4 There are no direct implications for sustainability. The Public Health Community Nursing Service aims to promote good health and

wellbeing for children, young people and their families and so can contribute to achieving the priorities for children and young people's health and wellbeing as set out in the Council's Corporate Plan, 2015 – 2019.

**Health, social care, children's services and public health**:

5.5 These considerations are integral to public health services as outlined in this paper

## Supporting documents and information

Appendix 1 Child Health Profile 2017 Brighton and Hove
Appendix 2 Summary of RED RAG rated health indicators
Appendix 3 Wider PHCN performance framework

Public Health England

# Child Health Profile

## March 2017

# Brighton and Hove

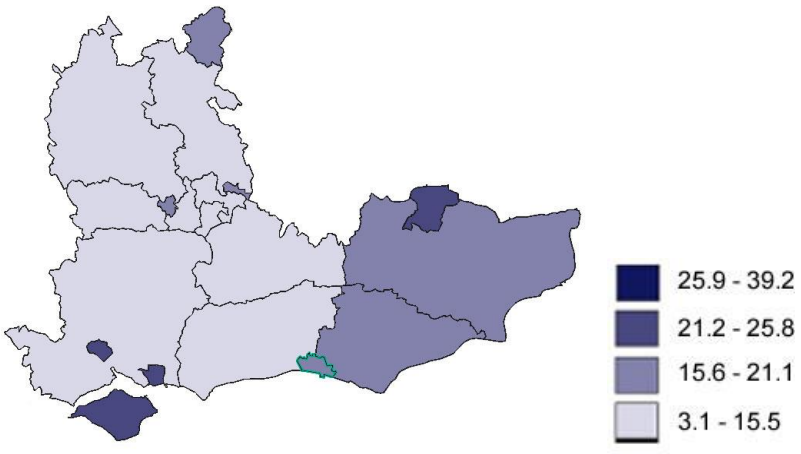
This profile provides a snapshot of child health in this area. It is designed to help local government and health services improve the health and wellbeing of children and tackle health inequalities.

## The child population in this area

| | | Local | Region | England |
|---|---|---|---|---|
| Live births (2015) | | 2,952 | 102,703 | 664,399 |
| Children aged 0 to 4 years (2015) | | 15,000<br>5.2% | 546,400<br>6.1% | 3,434,700<br>6.3% |
| Children aged 0 to 19 years (2015) | | 59,800<br>21.0% | 2,132,500<br>23.8% | 13,005,700<br>23.7% |
| Children aged 0 to 19 years in 2025 (projected) | | 63,300<br>20.8% | 2,304,700<br>23.8% | 14,002,600<br>23.8% |
| School children from minority ethnic groups (2016) | | 6,996<br>24.9% | 240,900<br>22.5% | 2,032,064<br>30.0% |
| Children living in poverty aged under 16 years (2014) | | 17.9% | 14.7% | 20.1% |
| Life expectancy at birth (2013-2015) | Boys | 79.3 | 80.5 | 79.5 |
| | Girls | 83.5 | 84.0 | 83.1 |

## Children living in poverty

Map of the South East, with Brighton and Hove outlined, showing the relative levels of children living in poverty.




## Key findings

Children and young people under the age of 20 years make up 21.0% of the population of Brighton and Hove. 24.9% of school children are from a minority ethnic group.

The health and wellbeing of children in Brighton and Hove is mixed compared with the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is better than the England average with 17.9% of children aged under 16 years living in poverty. The rate of family homelessness is similar to the England average.

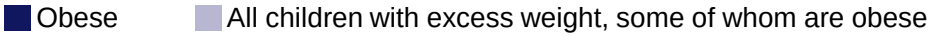
Children in Brighton and Hove have better than average levels of obesity: 6.8% of children aged 4-5 years and 13.8% of children aged 10-11 years are classified as obese.

The teenage pregnancy rate is higher than the England average. In 2015/16, 35 teenage girls gave birth which represents 1.3% of women giving birth. This is higher than the England average.

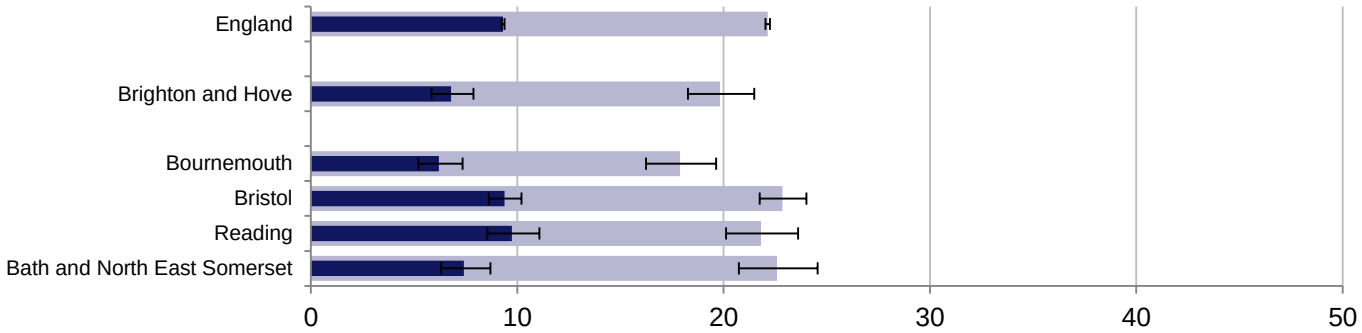
By six to eight weeks after birth, 71.5% of babies were breastfed in 2015/16, which is better than the England average. A higher percentage of mothers initiated breastfeeding in 2014/15 compared with the England average, with 87.9% breastfeeding.

## Childhood obesity

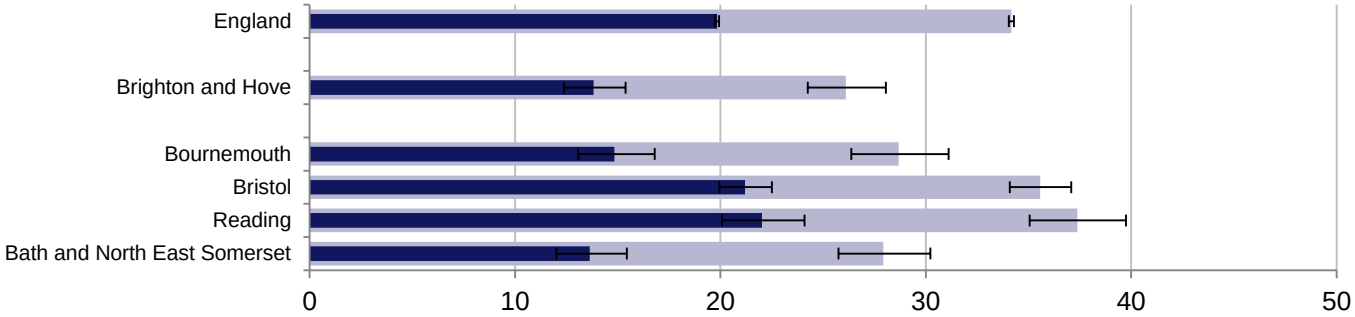
These charts show the percentage of children who have excess weight (obese or overweight) in Reception (aged 4-5 years) and Year 6 (aged 10-11 years). They compare Brighton and Hove with its statistical neighbours, and the England and regional averages. Compared with the England average, this area has a better percentage of children in Reception (19.8%) and a better percentage in Year 6 (26.1%) who have excess weight.




### Children aged 4-5 years who have excess weight, 2015/16 (percentage)




### Children aged 10-11 years who have excess weight, 2015/16 (percentage)



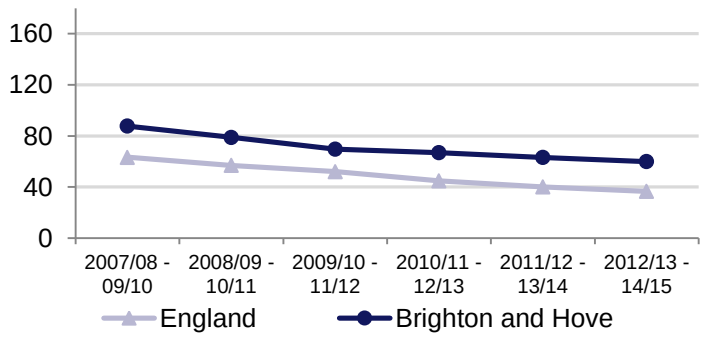

Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.

I indicates 95% confidence interval.

## Young people and alcohol

Nationally, the rate of young people aged under 18 being admitted to hospital because they have a condition wholly related to alcohol is decreasing, and this is also the case in Brighton and Hove. The admission rate in the latest period is higher than the England average.

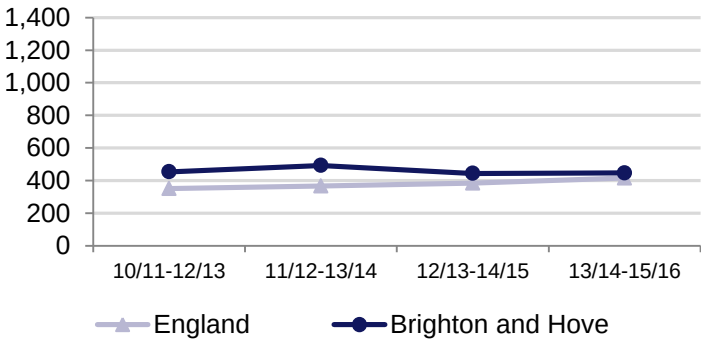
### Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)




## Young people's mental health

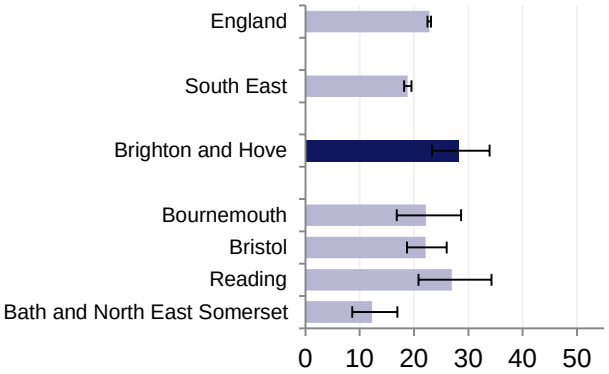
Nationally, the rate of young people aged under 18 being admitted to hospital as a result of self-harm is increasing. There is no significant trend in Brighton and Hove. The admission rate in the latest period is higher than the England average. Information about admissions in 2015/16 is on page 4. Nationally, levels of self-harm are higher among young women than young men.

### Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10-24 years)



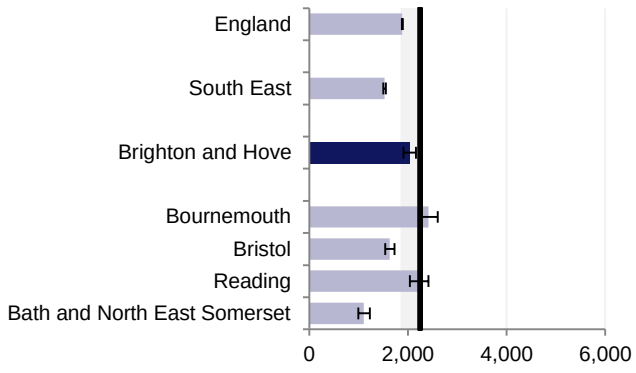
These charts compare Brighton and Hove with its statistical neighbours, and the England and regional averages.

## Teenage conceptions in girls aged under 18 years, 2014 (rate per 1,000 female population aged 15-17 years)




In 2014, approximately 28 girls aged under 18 conceived for every 1,000 women aged 15-17 years in this area. This is higher than the regional average (approximately 19 per 1,000). The area has a higher teenage conception rate compared with the England average (approximately 23 per 1,000).

## Chlamydia detection, 2015 (rate per 100,000 young people aged 15-24 years)



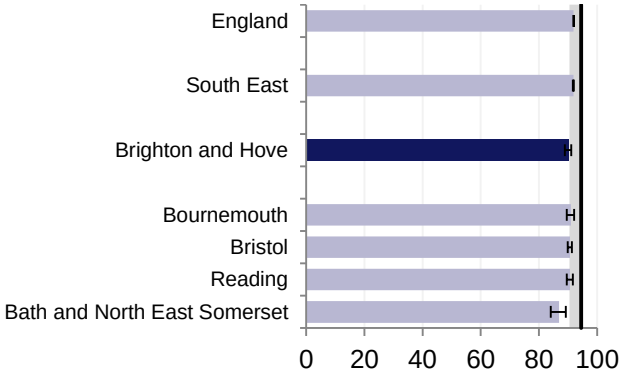

Chlamydia screening is recommended for all sexually active 15-24 year olds. Increasing detection rates indicates better targeting of screening activity; it is not a measure of prevalence. Areas should work towards a detection rate of at least 2,300 per 100,000 population. In 2015, the detection rate in this area was 2,033 which is approaching the minimum recommended rate.

The shaded area from 1,900 shows the range of values approaching the minimum recommended rate of 2,300 (the black line).

## Breastfeeding at 6 to 8 weeks, 2015/16 (percentage of infants due 6 to 8 week checks)


In this area 95.9% of babies received a six to eight week review by a health visitor before they turned eight weeks. At this point, 71.5% of babies were still breastfed which is higher than the national average.

## Measles, mumps and rubella (MMR) vaccination coverage by age 2 years, 2015/16 (percentage of eligible children)




Less than 95% (the minimum recommended coverage level) of children have received their first dose of immunisation by the age of two in this area (90.1%). By the age of five, only 82.7% of children have received their second dose of MMR immunisation. In the South East, there were 2 laboratory confirmed cases of measles in young people aged 19 and under in 2015.

The shaded area from 90% shows the range of values approaching the minimum recommended coverage of 95% (the black line).

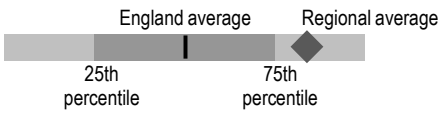
Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

# Brighton and Hove Child Health Profile March 2017

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.

↔ No significant change
↑↓ Increasing / decreasing and getting better
↑↓ Increasing / decreasing and getting worse
▪ Trend cannot be calculated

● Not significantly different from the England average
● Significantly better than England average
● Significantly worse than England average




| | Indicator | | Local no. per year* | Local value | Eng. ave. | Eng. worst | Eng. best |
|---|---|---|---|---|---|---|---|
| Premature mortality | 1 Infant mortality | ↓ | ***11*** | 3.8 | 3.9 | 7.9 | 2.0 |
| | 2 Child mortality rate (1-17 years) | ▪ | ***5*** | 9.7 | 11.9 | 20.7 | 5.3 |
| Health protection | 3 MMR vaccination for one dose (2 years) | ↑ | 2,463 | 90.1 | 91.9 | 69.3 | 97.7 |
| | 4 Dtap / IPV / Hib vaccination (2 years) | ↔ | 2,540 | 92.9 | 95.2 | 73.0 | 99.2 |
| | 5 Children in care immunisations | ↔ | 270 | 93.1 | 87.2 | 26.7 | 100.0 |
| Wider determinants of ill health | 6 Children achieving a good level of development at the end of reception | ▪ | 1,887 | 66.2 | 69.3 | 59.7 | 78.7 |
| | 7 GCSEs achieved (5 A*-C inc. English and maths) | ▪ | 1,231 | 60.3 | 57.8 | 44.8 | 74.6 |
| | 8 GCSEs achieved (5 A*-C inc. English and maths) for children in care | ▪ | 8 | 20.0 | 13.8 | 6.4 | 34.6 |
| | 9 16-18 year olds not in education, employment or training | ↓ | 350 | 4.8 | 4.2 | 7.9 | 1.5 |
| | 10 First time entrants to the youth justice system | ↓ | 56 | 260.1 | 368.6 | 821.9 | 126.6 |
| | 11 Children in low income families (under 16 years) | ↓ | 7,755 | 17.9 | 20.1 | 39.2 | 7.0 |
| | 12 Family homelessness | ↓ | 246 | 2.0 | 1.9 | 10.0 | 0.1 |
| | 13 Children in care | ↓ | 435 | 85 | 60 | 164 | 21 |
| | 14 Children killed and seriously injured (KSI) on England's roads | ▪ | ***7*** | 14.7 | 17.0 | 49.3 | 1.4 |
| Health improvement | 15 Low birth weight of term babies | ↔ | 74 | 2.7 | 2.8 | 4.8 | 1.3 |
| | 16 Obese children (4-5 years) | ↓ | 162 | 6.8 | 9.3 | 14.7 | 5.1 |
| | 17 Obese children (10-11 years) | ↓ | 281 | 13.8 | 19.8 | 28.5 | 11.0 |
| | 18 Children with one or more decayed, missing or filled teeth | ▪ | - | 16.2 | 24.8 | 56.1 | 14.1 |
| | 19 Hospital admissions for dental caries (0-4 years) | ▪ | ***32*** | 209.7 | 241.4 | 1,143.2 | 9.2 |
| | 20 Under 18 conceptions | ↓ | 114 | 28.2 | 22.8 | 42.4 | 8.4 |
| | 21 Teenage mothers | ↔ | 35 | 1.3 | 0.9 | 2.2 | 0.2 |
| | 22 Persons under 18 admitted to hospital for alcohol-specific conditions | ↓ | ***30*** | 60.0 | 36.6 | 92.9 | 10.9 |
| | 23 Hospital admissions due to substance misuse (15-24 years) | ▪ | ***47*** | 93.7 | 95.4 | 345.3 | 34.1 |
| Prevention of ill health | 24 Smoking status at time of delivery | ↔ | 185 | 6.3 | 10.6 | 26.0 | 1.8 |
| | 25 Breastfeeding initiation | ↑ | 2,681 | 87.9 | 74.3 | 47.2 | 92.9 |
| | 26 Breastfeeding prevalence at 6-8 weeks after birth | ▪ | 2,326 | 71.5 | 43.2 | 18.0 | 76.5 |
| | 27 A&E attendances (0-4 years) | ↓ | 8,722 | 582.6 | 587.9 | 1,836.1 | 335.0 |
| | 28 Hospital admissions caused by injuries in children (0-14 years) | ↔ | 448 | 104.1 | 104.2 | 207.4 | 53.5 |
| | 29 Hospital admissions caused by injuries in young people (15-24 years) | ↓ | 466 | 94.7 | 134.1 | 280.2 | 72.0 |
| | 30 Hospital admissions for asthma (under 19 years) | ↔ | 85 | 155.6 | 202.4 | 591.6 | 84.3 |
| | 31 Hospital admissions for mental health conditions | ↔ | 40 | 78.1 | 85.9 | 179.8 | 33.8 |
| | 32 Hospital admissions as a result of self-harm (10-24 years) | ↔ | 284 | 447.5 | 430.5 | 1,444.7 | 102.5 |

● ≥95% ● <90%
● 90% to 95%

*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure

Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box

**Notes and definitions**

**1** Mortality rate per 1,000 live births (aged under 1 year), 2013-2015
**2** Directly standardised rate per 100,000 children aged 1-17 years, 2013-2015
**3** % children immunised against measles, mumps and rubella (first dose by age 2 years), 2015/16
**4** % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2015/16
**5** % children in care with up-to-date immunisations, 2016
**6** % children achieving a good level of development within Early Years Foundation Stage Profile, 2015/16
**7** % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2015/16
**8** % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2015
**9** % not in education, employment or training as a proportion of total 16-18 year olds known to local authority, 2015
**10** Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2015
**11** % of children aged under 16 years living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2014
**12** Statutory homeless households with dependent children or pregnant women per 1,000 households, 2015/16
**13** Rate of children looked after at 31 March per 10,000 population aged under 18 years, 2016
**14** Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2013-2015
**15** Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2015
**16** % school children in Reception year classified as obese, 2015/16
**17** % school children in Year 6 classified as obese, 2015/16
**18** % children aged 5 years with one or more decayed, missing or filled teeth, 2014/15
**19** Crude rate per 100,000 (aged 0-4 years) for hospital admissions for dental caries, 2013/14-2015/16
**20** Under 18 conception rate per 1,000 females aged 15-17 years, 2014
**21** % of delivery episodes where the mother is aged less than 18 years, 2015/16
**22** Persons admitted to hospital due to alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population, 2012/13-2014/15
**23** Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2013/14-2015/16
**24** % of mothers smoking at time of delivery, 2015/16
**25** % of mothers initiating breastfeeding, 2014/15
**26** % of mothers breastfeeding at 6-8 weeks, 2015/16
**27** Crude rate per 1,000 (aged 0-4 years) of A&E attendances, 2015/16
**28** Crude rate per 10,000 (aged 0-14 years) for emergency hospital admissions following injury, 2015/16
**29** Crude rate per 10,000 (aged 15-24 years) for emergency hospital admissions following injury, 2015/16
**30** Crude rate per 100,000 (aged 0-18 years) for emergency hospital admissions for asthma, 2015/16
**31** Crude rate per 100,000 (aged 0-17 years) for hospital admissions for mental health, 2015/16
**32** Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2015/16

| Red Rated Child Health Profile indicators | PHCN contribution |
|---|---|
| Children in Care | • All the health reviews for Children in Care are completed by the PHCN service (6 monthly for under 5s and yearly for school age).<br>• Health action plans are agreed where health needs identified. |
| 16 – 18 NEET | • The PHCN service has been extended to the age of 19 from April 2017. SCFT now have a service level agreement with youth workers to jointly deliver the extended offer. SCFT and youth workers at the consultation stage to design the offer. Signposting to NEET support will be included<br>• Healthy Futures Team will work with young parents to link to EET and provide appropriate support to access childcare. |
| Children achieving a good level of development at the end of reception | • See everyone at 2 ½ year review and develop an action plan for those in need of support.<br>• Provide integrated reviews for UPP families and develop an action plan for those in need of support.<br>• Developing a questionnaire at 3 – 4 to add parental information to planning process for children.<br>• The PHCN service has strong links with early help<br>• Historically all children transitioned their health care from the health visitor (HV) to the school nurse when they started school. Now if there is identified need for the child, the named HV will hold the case until the child is more settled. |
| Teenage Conception | • School health drop-ins at school where contraception and sexual health screening is provided<br>• CHATHEALTH – text messaging service.<br>• Consulting on new 16 – 19 offer<br>• Health promotion<br>• Healthy Futures work directly with young parents<br>• Strong working relationship with the PH Schools team, schools and wider partners to have a whole school approach to health issues. |
| Persons under 18 admitted to hospital for alcohol related conditions. | • School health drop-ins at school where substance misuse screening is implemented.<br>• CHATHEALTH – text messaging service.<br>• Consulting on new 16 – 19 offer<br>• Health promotion<br>• Health Improvement Specialist provides stop smoking support in Schools<br>• Strong working relationship with the Public Health Schools Team, schools and wider partners to have a whole school approach to health issues. |

## Appendix 3: New PHCN contract performance framework

The PHCN performance framework is extensive and is based on the NHS Healthy Child national guidance, informed by local intelligence and PHE Regional feedback. It consists of:

- **Service specific measures of input and activity** used to monitor progress towards achievement of a range of overarching population health outcomes and includes:
    - caseload receiving the service broken down by levels of service and by age groups (0- 5 years and 5-19 years)
    - proportion of families receiving face to face contacts from the service (new birth antenatal visits, new birth visits within 14 / 17 days, 6 – 8 week reviews, maternity mood reviews, 12/15 months reviews, 2 year review and integrated 2 ½ year review)
    - distribution of questionnaires by age groups and follow up support
    - National Child Measurement Programme and vision and hearing tests
    - Drop in sessions - schools and other youth settings
    - CHATHEALTH contacts and conversation themes
    - Referrals
    - Interventions completed
    - Responsiveness of the service

- **Outcomes measures** for the anticipated benefits in health status or determinants of health status resulting from Healthy Child Programme (HCP) promotion, prevention and early intervention activities. These are:
    - Service user satisfaction - this will be broken down by intervention type as well as by demographic information.
    - HCP themes: each will have targets set or 2017/18 will be the baseline year for developing the target
        - Transitions to parenthood and the early weeks
        - Maternal mental health
        - **Breastfeeding**
            - Percentage of infants being breastfed (fully or partially) at 6-8 weeks 72%.
            - Percentage of infants being breastfed (fully) at 6-8 weeks. (baseline year 2017/18)
        - Healthy weight, healthy nutrition
        - Managing minor illnesses and reducing hospital attendance/admissions
        - Health, wellbeing and development of the child aged 2 & support to be 'ready for school'
        - Resilience and emotional wellbeing
        - Keeping safe: managing risk and reducing harm
        - Improving lifestyles
        - Maximising learning and achievement
        - Supporting complex and additional health and wellbeing needs

*Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.*

## 1. Siblings W and X Serious Case Review – Published 27 July 2017

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 12 September 2017.

1.3 Author of the Paper and contact details
Mia Brown
LSCB & SAB Business Manager
Mia.brown@brighton-hove.gcsx.gov.uk

## 2. Summary

2.1 This paper presents the learning from a Brighton & Hove Serious Case Review.

2.2 The Serious Case Review concerned two siblings, W and X, who originated from a country in North Africa / Middle East and received services from local agencies. Both siblings travelled to Syria aged under eighteen years old and both are reported to have died in 2014, the elder soon after his eighteen birthday and the younger at age seventeen.

2.3 The review was formally published on 27 July 2017.

2.4 The LSCB formally accepted the report at its Extraordinary Meeting on 3 April 2017.

2.5 The Department for Education, Home Office, Prevent Board, local MPs and Lead Councillors have been briefed on the learning from the review.

## 3. Decisions, recommendations and any options

3.1 That the Board note the actions of the LSCB in developing the action plan in response to the findings of this serious case review.

3.2 That the Board requests the LSCB provide an update on the action plan as part of its annual reporting.

## 4. Relevant information

4.1 The Serious Case Review concerned two siblings, W and X, who originated from a country in North Africa / Middle East and received services from local agencies. Both siblings travelled to Syria aged under eighteen years old and both are reported to have died in 2014, the elder soon after his eighteen birthday and the younger at age seventeen. It was understood that the boys were with the Al-Nusra Front, which in 2013 pledged allegiance to Al Qaeda.

4.2 The review was commissioned to support the identification of the strengths and gaps in multi-agency responses, in the city of Brighton & Hove, to vulnerable adolescents at risk of exploitation through radicalisation.

4.3 The review covered the period of January 2012 – October 2014. Practitioners, senior managers, community members, Imams and the boys' mother contributed to the review.

4.4 The review examined the siblings and their family's experiences. This included their experience of being subjected to racist and religiously motivated abuse and attacks, domestic abuse and physical abuse. The review also considered the youngest four siblings' involvement in anti-social and criminal activities.

4.5 The review found that prior to the siblings travelling, the national intelligence and threat assessment did not suggest that young people were travelling abroad to fight, nor did local professionals identify that the siblings were at risk of being vulnerable to radicalisation or at risk of travelling to join fighting abroad.

4.6 The review identified 13 findings. These findings have been grouped into the following priority areas:

- Priority Area 1: Working with trauma (Finding 1)
- Priority Area 2: Working with high risk adolescents (Findings 2,3,4,5)
- Priority Area 3: Working with children vulnerable to radicalisation (Findings 6,7,8, 9,10)
- Priority Area 4: Working with minority ethnic groups (Findings 11,12,13)

4.7 We have not replicated the full report and action plan here as they are already in the public domain. The report and safeguarding board response are here: - **http://www.brightonandhovelscb.org.uk/sibling-wx-serious-case-review/**

4.8 The report is structured as follows

- Section 1 provides an introduction to the case.
- Section 2 provides a brief explanation of the review approach and the learning aims of the serious case review
- Section 3 describes the global and national context in relation to radicalisation and the recent emergence of young people wishing to go to Syria
- Section 4 explains the historical context of professional intervention with the family prior to the review period
- Section 5 gives an overview appraisal of professional practice at the time (January 2012 - October 2014), summarising what happened and why
- Section 6 presents the detailed series of 13 findings along with accompanying considerations for the LSCB
- Section 7 provides the conclusions of the review
- The appendix provides information on the review team who worked together with the lead reviewers in this serious case review
- The glossary of acronyms and terms used in the report are provided at the end of the report

4.9 An action plan has been developed and actions against the 13 findings are being monitored by the LSCB Serious Case Review Subcommittee, with progress reported to the LSCB.

Actions include:

- The Board, with partners, to develop training to support the understanding of the impact of early childhood trauma, to include the impact of PTSD and the understanding of neuro-science and the impact of early childhood trauma upon brain development

- The Board to evaluate the work of the Adolescent Board, once established, and the multi-agency response in meeting the needs of high risk adolescents.

- The Board to seek clarification from the Government regarding expectations of notifying and the working arrangements between local authorities, the Government and counter terrorism

- The Board to explore the benefits, in terms children's welfare, of schools and social care services being notified of all children who come into contact with the police.

- Given the links between racism and radicalisation highlighted in the review, the Board to seek clarification from the Government as to why experience of racism in schools is no longer a statutory reporting requirement

- The Board to request Counter Terrorism Policing South East to formally respond to the review's findings. In particular, to provide clarity around how police officers resolve potential conflicts between the security of the state and the safeguarding of children involved in such investigations.

- The Board Learning & Development Officer to work with and support Imams and members of mosques to deliver training and consultancy around domestic abuse, child safeguarding and child protection.

- The Board, in partnership with the Community Safety Team to continue to develop links with local Muslim communities. This includes identifying local community advocates/safeguarding leads to help the Board and the communities engage in a dialogue to strengthen local arrangements for all children and families.

4.10 The LSCB have accepted the findings from this review and there is a real appetite amongst partners to address the issues identified. Media coverage of the review was largely positive.

Media coverage included:

- National newspapers: (Guardian, Times, Telegraph, Daily Mail, Mirror, Independent).
- Regional/local newspapers: (Argus x4, Brighton & Hove News x2, Chichester Observer)
- National TV: (Sky, BBC and ITV)
- International TV: (Russia Today)
- National Radio: (Various news bulletin coverage across national commercial and BBC radio, including BBC Radio 2)
- Regional/local TV: (ITV Meridian, BBC South East Today)
- Regional/local Radio: (BBC Sussex: Various news bulletin coverage; extensive breakfast show coverage, Juice Brighton, Heart Sussex
- Other online coverage: (Breitbart News, Yahoo News)

## 5. Important considerations and implications

Legal

5.1 It is a statutory requirement that safeguarding reviews are commissioned and published. It is also in the terms of reference that reviews should come to the Health and Wellbeing Being Board

Lawyer consulted: Sandra O'Brien Date: 31/08/2017

Finance

5.2 There are no financial implications as a direct result of the recommendations of this report. The LSCB and safeguarding reviews have an agreed budget with multi-agency funding. An annual report is provided to the HWB outlining budget intentions and past spend.

Finance Officer consulted: David Ellis Date: 31/08/2017

Equalities

5.3 The LSCB through the City Council and other partner agencies will continue to work to ensure all children and families have access to safeguarding services – particularly those who are less able to

communicate due to age, disability, language or for other reasons. One of the key objectives of the LSCB is to improve outcomes for children and young people from diverse communities and groups, and for those who live in deprived geographical communities.

Sustainability:

5.4 This report affects the One Planet principle: Health & Happiness. There are actions in place to encourage active, sociable, meaningful lives to promote good health and well being.

Health, social care, children's services and public health:

5.5 The report details health, social care and public health implications.

## Supporting documents and information

Appendix 1 Serious Case review summary presentation

Siblings W & X Serious Case Review – Full Report [available online] http://www.brightonandhovelscb.org.uk/wp-content/uploads/Siblings-W-and-X-SCR-July-2017.pdf

LSCB Learning & Improvement Report – Siblings W&X [available online] http://www.brightonandhovelscb.org.uk/wp-content/uploads/W-X-Learning-Improvement-Report.pdf

# Serious Case Review: Siblings W and X

Edi Carmi & Anna Gianfrancesco
Lead Reviewers



Brighton & Hove LSCB local safeguarding children board

# Methodology

- SCIE Learning Together Review
- Collaborative approach with review team
- Participative approach with staff through 38 data collection conversations + 3 group analysis / feedback opportunities
- Repeated attempts to involve family
- Repeated attempts to involve Mosques
- 2 meetings offered to members of the community
- Scope: January 2012 – October 2014

# Case Summary

**CONTEXT**

- 18 year old W died in Syria in April 2014 and 17 year old X died in October 2014
- Understood to have joined elder brother P who left England in autumn 2013 and in 2014 also understood to be in Syria
- Police learnt over several weeks from their disappearance in late January 2014, that the brothers (and another friend) went to Turkey and then to Syria to join Al-Nusra Front

**OVERALL SUMMARY**

- **Overall summary of case review is the challenges for professionals in being able to provide effective help and support to children who have suffered trauma in their early childhood**

# Family known to local agencies

- W and X part of large sibling group
- Family well known to local agencies because PRIOR to period under review history of:
  - Family, including children, suffered severe racism
  - Domestic abuse
  - Physical and emotional abuse of children: child protection plan until?
- Multitude of services provided at times

# Period under review: 2012-2014

- Educational attendance of 4 youngest decreased
- Anti-social and criminal activities up (4 youngest)
- No concerns about radicalisation or of travelling abroad to fight of these boys, or at the time of other children- except for one Channel Panel referral around anti-American comments of X (Autumn 2013)
- Following discovery boys went to Syria, agencies aware of potential risks to other young people in Brighton & Hove, particularly in the siblings peer group

# Working with High Risk Adolescents

## 4 FINDINGS (1,2,5 & 6)

**Finding 1:** Does the recent expansion of child protection processes to cover adolescents at risk of Child Sexual Exploitation or exploitation into radicalisation, adequately cover other types of adolescent risk of harm, such as that associated with truancy and involvement in anti-social, criminal or risky behaviour?



**Finding 2:** The current child protection processes distinguish between children who are missing in the UK and those are who are suspected of being missing abroad; as a consequence the potential positive strategy involved in the formulation of a child protection plan is not provided for those who are suspected of being abroad

# Working with High Risk Adolescents:

**Finding 5:** In working with adolescents there can be a pattern of reactive crisis management as a means of handling the relentless stream of incidents; this minimises the likelihood of reflective thinking and analysis necessary to understand and tackle the root causes of the behaviour



**Finding 6:** The systems of collecting and sharing data about young people who come to police attention, in Brighton & Hove, do not consistently provide all relevant information to practitioners so as to assess, identify and address safeguarding needs?

# Working with Trauma

**Finding 3:** Professionals do not have effective ways to intervene in families who have suffered long standing trauma in the past and whose previous experience of professional intervention was not perceived positively. In such circumstances the chance of mothers or their children feeling able to trust professionals decreases and the risks of young people being vulnerable to exploitation increases



# Working with Minority Ethnic Groups

**Finding 4:** Does the multi-agency safeguarding system have the resources and strategies available to consistently help abused women and children from minority cultural backgrounds, if they fear that co-operating with statutory authorities could lead to the loss of support of their wider family and community?



**Finding 7:** Do practitioners have sufficient curiosity, knowledge, and skills to explore the role of culture, identity, religion, beliefs and potential divided loyalties experienced by some children & families?

**Finding 12:** Brighton & Hove statutory agencies have insufficient knowledge about, and understanding of, local minority ethnic and faith community groups and how best to work together to safeguard children, including those at risk of exploitation of local children into radicalisation

# Working with Children Vulnerable to Radicalisation

**Finding 8:** Professional responsibilities arising from the government's counter terrorism strategy are new, not yet fully understood by all relevant staff and subject to ethical dilemmas: this presents challenges in being able to reliably recognise both the risk of radicalisation and the potential links to safeguarding concerns.

**Finding 9:** Do practitioners understand and know how young people are radicalised in Brighton & Hove and how to counter the propaganda that influences them into extremist thinking?

**Finding 10:** The lack of a well-established working relationship between counter terrorism police officers and other agencies can lead to an atmosphere of suspicion between professionals of inappropriate confidentiality, which could compromise children's safeguarding.

# Working with Children Vulnerable to Radicalisation

**Finding 11:** Does the timely and constructive response of B&H to the newly identified safeguarding risks to children posed by radicalisation, represent a systems strength?

**Finding 13:** Efforts to help and support children so they are less likely to become vulnerable to exploitation into radicalisation, do not seem to adequately address all the core issues, as perceived by community members

# Safeguarding is Everybody's Business

Brighton & Hove LSCB local safeguarding children board