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

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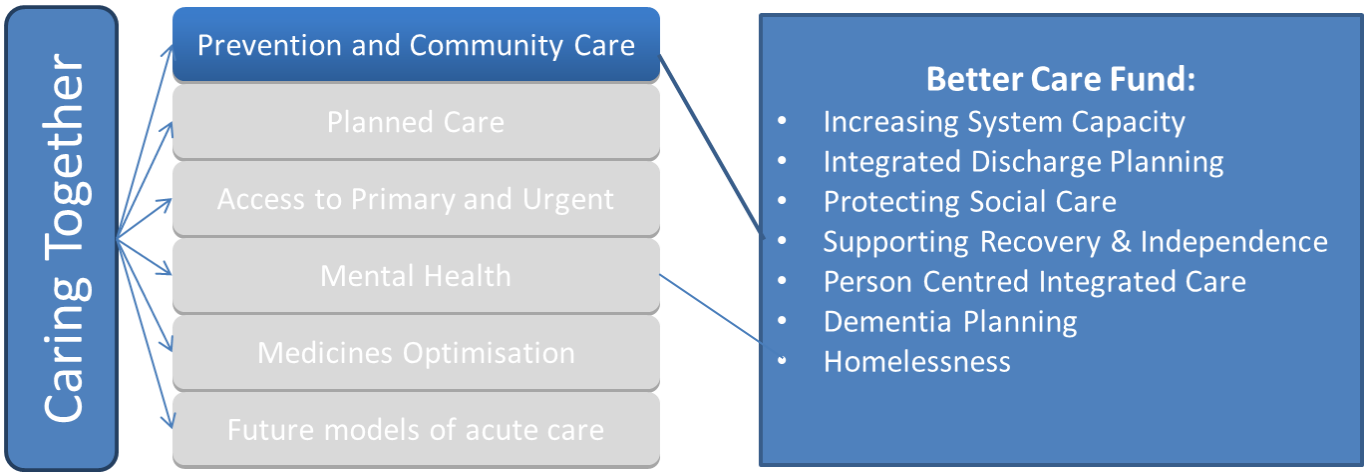
Introduction / Foreword

- 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:

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Geoff Raw, Chief Executive of Brighton and Hove City Council

Brighton and Hove Health and Wellbeing Board:

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Cllr Daniel Yates, Chair of Health and Wellbeing Board

Brighton and Hove Clinical Commissioning Group:

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

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

Healthwatch:

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Sussex Community Foundation Trust:

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Brighton and Sussex University Hospital Trust:

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Sussex Partnership Foundation Trust:

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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.

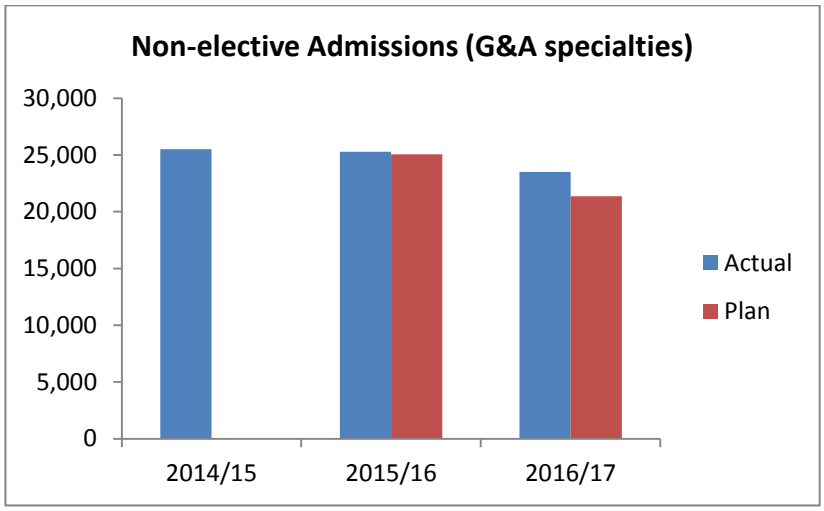
We know that demand for services is increasing and that, coupled with an ageing population, this is likely to continue. Over recent years we have mitigated any increase in the number of A&E attendances and unplanned admissions by developing and strengthening our community services. Our plans for 2016-17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

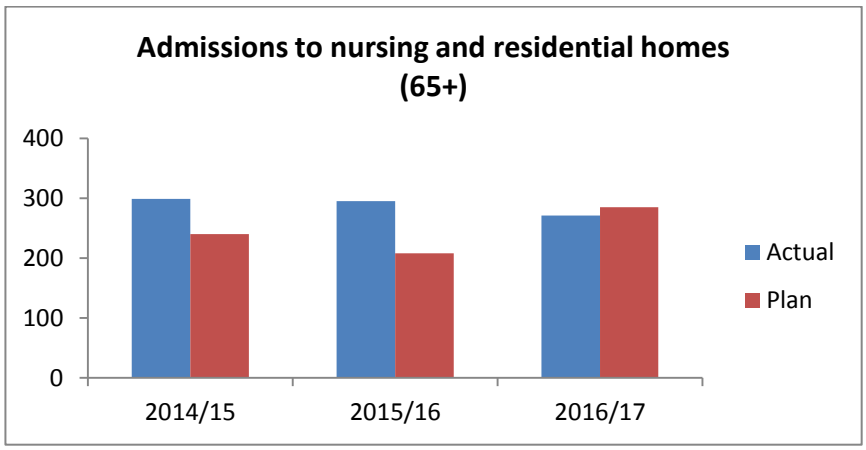
Non elective admissions:

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).



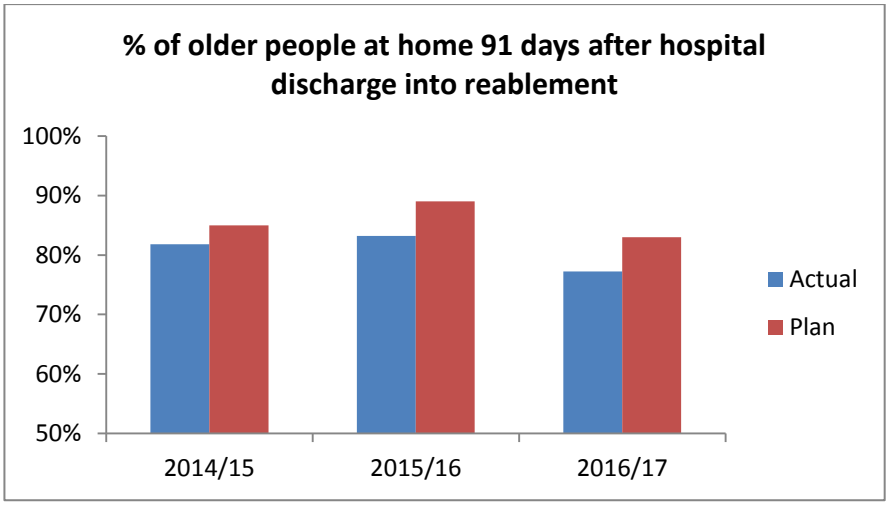
Care Home Admissions:

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



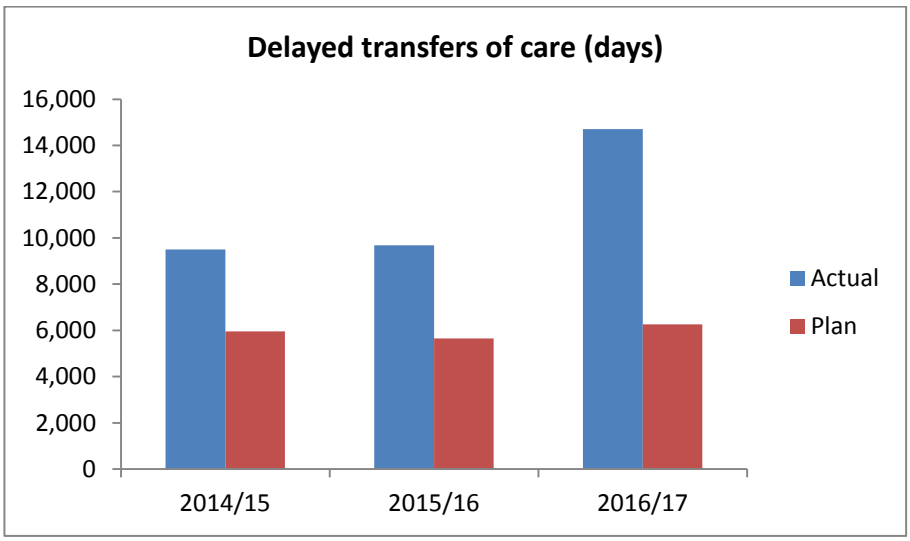
Reablement:

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

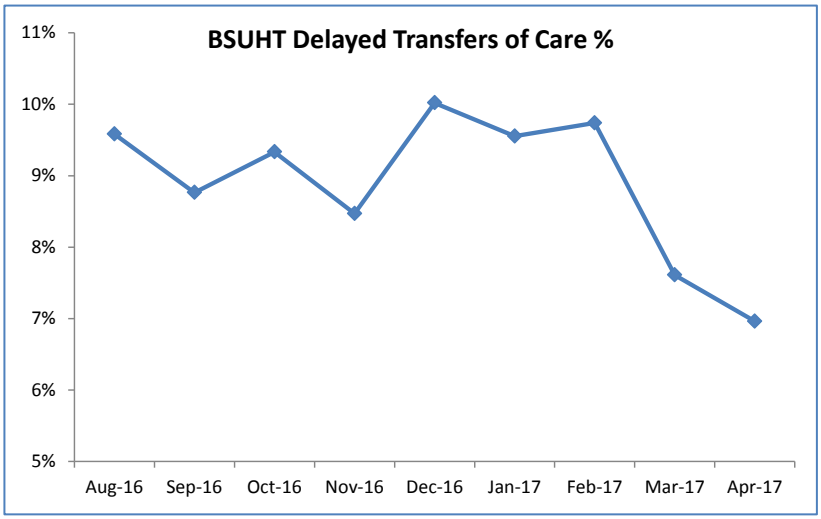


Chart 1: Brighton and Sussex University Hospital trust days delayed August 16 to May 17

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).

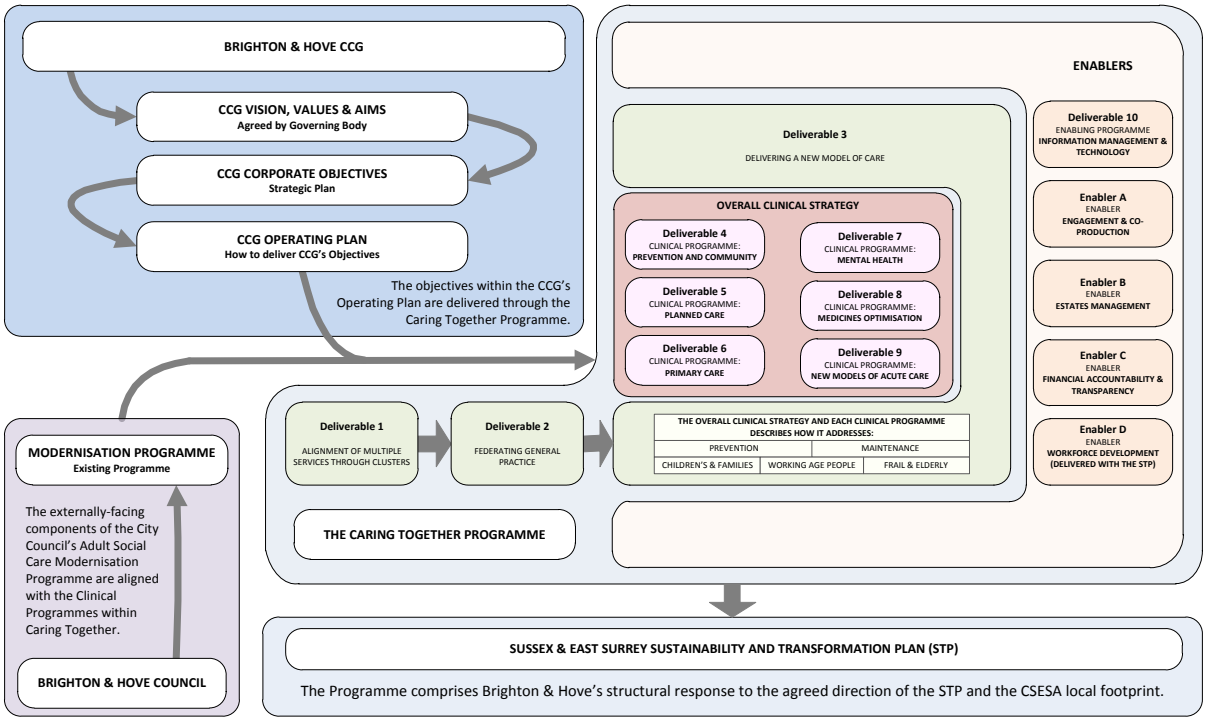
The Caring Together Programme

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.

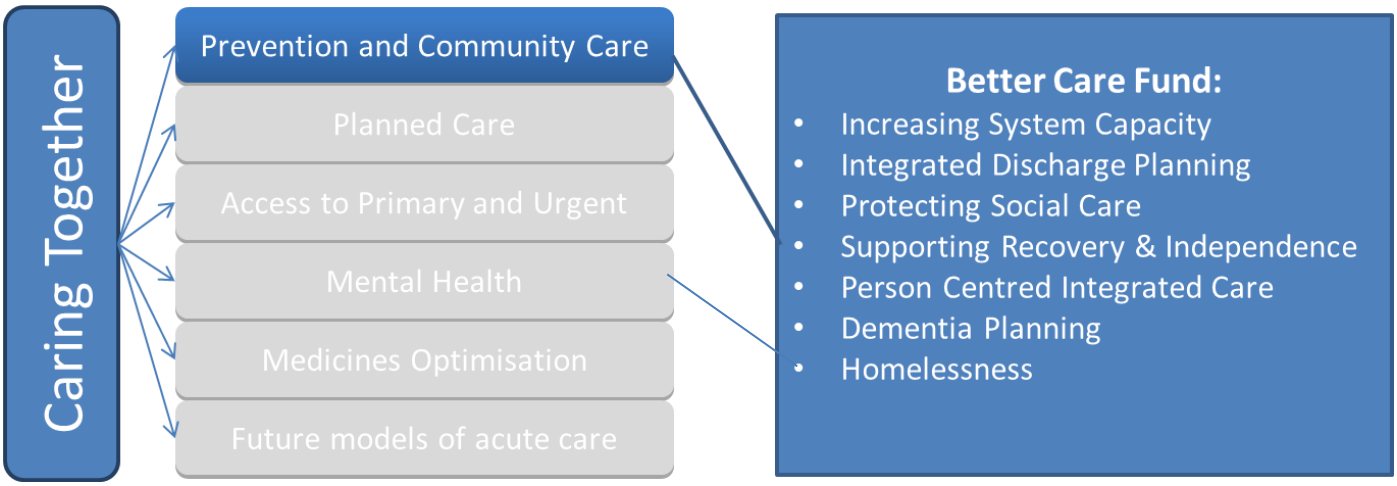


The Programme comprises six programmes

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

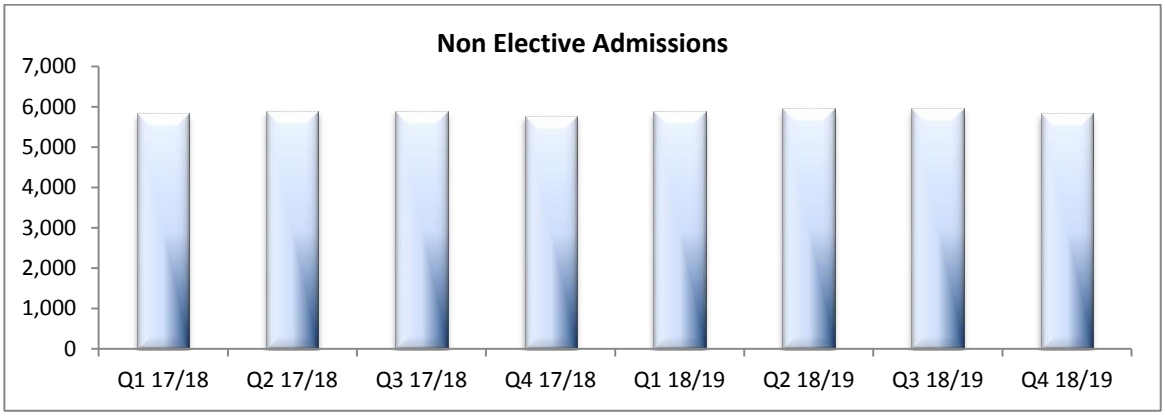
National Metrics

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

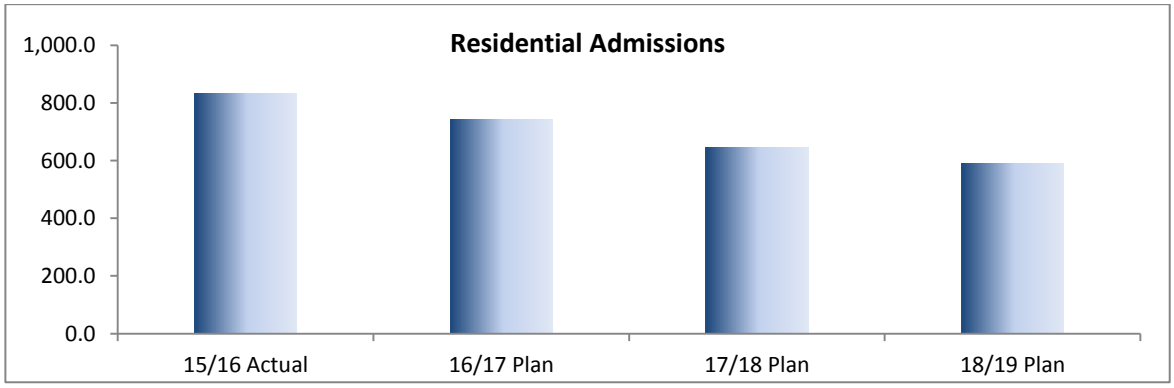
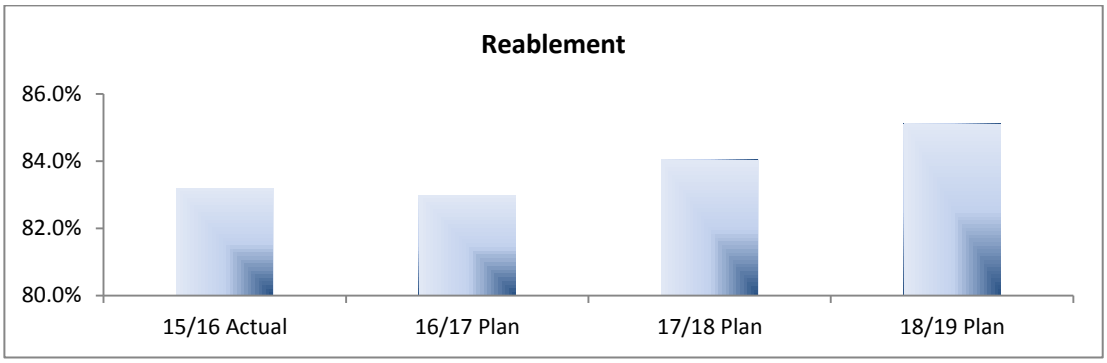


Table 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

	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

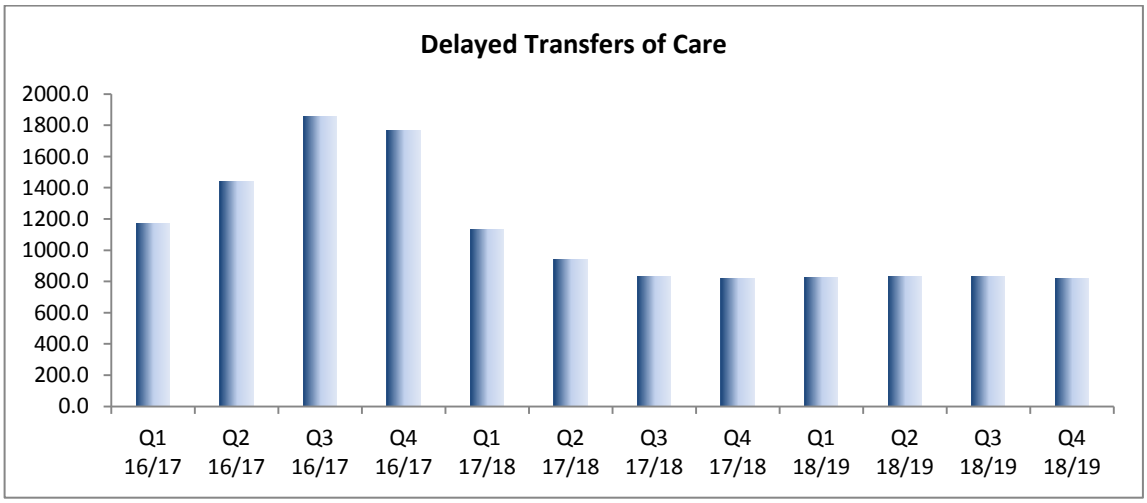


Delayed transfers of care

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** 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 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. 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. Evaluate communication and reporting mechanisms for tracking patient progress to streamline processes and maximise efficiency	Ongoing October 2017	Reduction in discharge delays (see trajectory contained in appendix 2) Reduction in DTOCs (see trajectory contained in appendix 2) Reduction in in overall Length of Stay Positive self-reported patient outcomes
	Well established HRDT- MDT working in ED/ Acute floor. Assessment/ 'screen' and DC planning commences quickly Provider led referral hub to provide appropriate	Establish Early Identification programme to improve identification of patients requiring supported DC. 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 Improved patient experience Reduction in LOS 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. Care Matching team in place to ensure timely sourcing of placements and packages of care. Information available on a daily basis. Community Beds- daily rounds in CV and KH Daily review of all SW allocated work by Senior SW both in acute and community bedded settings	patients to facilitate timely discharge. 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 Reduction in DTOCs in the community setting 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. 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. Daily CC (12 o'clock)- to: • Exchange clear information regarding all complex/ supported discharges • Ensure prompt escalation where required • Problem solve together • 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. Continue multi agency approach sharing themes and best practice to improve the system as a whole 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 By September 2017 By September 2017	Improved data on demand and understanding of patient level costs across health and social care Reduction in discharge delays (see trajectory contained in appendix 2). Reduction in DTOCs (see trajectory contained in appendix 2) Reduction in in overall Length of Stay Reduction in DTOC Positive self-reported patient experience 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 Daily conference call with Social Care Care Matching Team 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 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 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. Multi-agency Falls Prevention steering group guiding multidisciplinary approach to falls prevention. A set of key shared awareness communications messages agreed across all partners. A programme of awareness/prevention training for key services is underway. Specific training for providers of physical activity classes piloted. Clarification of signposting and referral routes across and between services.	Recruit Falls Co-ordinator to work with Public Health team. Further awareness raising and prevention messages across the H&SC system, Community & Voluntary sector, independent sectors and also with public. Build on existing training offering general awareness for all services and more targeted information for those working with older people. 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,. Commissioned Otago and PSI training for more	August 2017 – Oct 2017 Year1 Nov 2017 – April 2018 Nov 2017 – April 2018	Falls Co-ordinator in post 0.4 FTE Awareness communications campaign in place and widely used across sectors Bespoke training commissioned and rolled out. All placed filled and positively evaluated. Bespoke training commissioned and rolled out. All placed filled and positively evaluated. 3-6 x Strength and Balance classes being delivered in the community each week. Each to include pre and post assessments. 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'. Establish Home Safety Checks in partnership with East Sussex Fire and Rescue. Agreed annual number of checks. 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. 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 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. Completed assessment of model, achievement of outcomes, financial modelling / cost savings. Reduced injuries due to falls 65+ Reduce hip fractures in people 65 + Reduce hospital attendance from falls 65+ System in place for signposting and referrals for those identified at higher risk. 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 **Social prescribing** to support appropriate patients post discharge **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 Review the social prescribing service and integrate with other discharge support initiatives. Lead Pharmacist Medicine currently on ward MDTs	Aug 18 Social prescribing review: Oct 17 Already achieved	Service offer is delivered consistently across the system. Increase in patients supported; good self-reported patient outcomes 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 Roll out: Sep 17	Service offer is delivered consistently across the system Reduction in LOS. 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: -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	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 Funding allocated and plans in development to incentivising care homes and homecare providers to respond 7 days	Baseline: Aug 17 Plan: Sep 17	Increased number of discharges over the weekend from acute, mental health and community settings 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 . 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 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) 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. 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 CHC checklist – Oct 17 to Mar 18 Review Jan Feb 18 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 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. 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'.	Regular staff training and updating sessions will help to ensure the policy continues to be used widely and proactively. 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. Further rollout of Let's Get You Home policy across Mental Health and Community settings Embed Red Cross and Age UK 'Take Home and Settle Service' within community services providing reablement beds and services.	September 2017 By September 2017 Continuing awareness raising	Reduction DTOC (patient or family choice reasons across acute, mental health and community setting) Reduction in DTOCs Reduction in in overall Length of Stay Numbers of patients seen by the service increases Positive self-reported patient outcomes 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 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 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. 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. 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 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. 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 Work with ambulance service to identify outlier Homes with high frequency hospital admissions, broken down by reasons for conveyance. 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. 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 October 2017 Proposed Telehealth pilot November 2017	Consistency in primary care support reported by Homes. Reduction in delays initiated by care homes 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. 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 Delayed Days per day per 100,000 18+ population (awaiting completion of assessment) Delayed Days per day per 100,000 18+ population (awaiting residential home placement or availability) Delayed Days per day per 100,000 18+ population (awaiting nursing home placement or availability) 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 Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services Delayed transfers of care (days) % Emergency readmission within 30 days of discharge from hospital (B&H CCG) Average Length of Stay for older people (65+)
Protecting Social Care	Proportion of support plans that have a % telecare as a component Telecare service user satisfaction (95% target) Number of people supported through Telecare (620 per annum) % of users receiving long-term community support who received self-directed support % of users receiving long-term community support who received direct payments or part direct-payments % of equipment delivered/collected in time % 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 % of carers receiving carer specific services who received direct payments or part direct-payments % of adult carers who have as much social contact as they would like
Person Centred Integrated Care	Non-elective Admissions (G&A specialties) Admissions to nursing and residential homes (65+) Percentage of patients receiving a Whole Person Assessment against the roll-out plan (v3) % of Proactive Care patients received face-to-face appointments within 4 weeks Average Length of Stay for older people (65+)
Dementia Planning	Dementia Diagnosis rate 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.