Appendix 1

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Brighton and Hove City Council**
Clinical Commissioning Groups	**Brighton and Hove Clinical Commissioning Group**
Boundary Differences	**The City Council and CCG boundaries are coterminous**
Date agreed at Health and Well-Being Board:	**05/02/14**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£5,631**
2015/16	**£18,065**
Total agreed value of pooled budget: 2014/15	**£5,631**
2015/16	**£18,065**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Brighton and Hove Clinical Commissioning Group
By	Dr Christa Beesley
Position	Chief Clinical Accountable Officer
Date	

Signed on behalf of the Council	Brighton and Hove City Council
By	Catherine Vaughan

Position	Executive Director of Finance & Resources
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Brighton and Hove Health & Wellbeing Board>
By Chair of Health and Wellbeing Board	Rob Jarrett
Date	<date>

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Our Better Care Plan in Brighton and Hove focuses on delivering an integrated model of care for frailty across the City as we believe this is the cohort of people most likely to benefit from an integrated system. In Brighton and Hove we have taken a broad definition of frailty rather than just focus on older people who are frail. The definition we are using is "*a state of high vulnerability for adverse health outcomes, including disability, dependency, falls, need for long-term care, and mortality*." (Fried, Ferrucci, Darer, Williamson, & Anderson, 2004)[1][2]

A vision for a more integrated model of care for our frail population was originally initiated by the Urgent Care Clinical Forum – a group of clinicians and social care colleagues representing providers across primary, community and acute settings, the independent social care sector, and the community & voluntary sector. The Forum has been working on a new model of care for frailty since September 2013 and their driving principle was to ensure that a new model was co-designed and underpinned by a widespread coalition of professional opinion.

Two Implementation Boards – one focusing on frailty and one focusing specifically on homelessness are now up and running to take forward the vision developed by the Clinical Forum. These Boards comprise senior clinical and executive level representation from all partner agencies including Brighton and Sussex University Hospital Trust, Sussex Community Trust, Sussex Partnership Foundation Trust, independent sector Nursing Homes, the Community & Voluntary Sector, Adult Social Care and 3 CCGs working around the catchment population of BSUH i.e. Brighton and Hove, Horsham and Mid Sussex, and High Weald, Lewes, Havens.

A Better Care Programme Board for the City has produced and signed off the Plan. (currently this Board comprises Health, Social Care and Housing representation but membership is being broadened to include Provider representation)

A bi-monthly meeting of CEOs across the City – chaired by the CEO of Brighton and Hove City Council will take place following an initial meeting to ensure senior level support to this large scale change programme. The high level Plan was presented to CEOs at its January meeting and they have agreed to consider ways

[1]

[2] http://consultgerirn.org/topics/frailty_and_its_implications_for_care_new/want_to_know_more

to enable further integration of services. CEOs (or their representatives) will be part of the Better Care Programme Board.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The Brighton and Hove vision for an integrated model of care is based on feedback from public, patients, service users and carers drawn from a wide range of sources including:

- **In February 2013, Age UK Brighton and Hove recorded patient and service user experiences within Community Short Term Services, which is a multi-provider service for intermediate care focussing on avoiding unnecessary hospital admissions and supporting timely discharge from hospital for reablement and rehabilitation. The focus was on systems, processes, and user understanding and satisfaction with care. The outcome of this feedback formed a baseline and has informed future integrated model planning.**
- **Public events where feedback was sought on key service areas. Themes emerging from specific events on 14th May 2013, 15 October 2013 highlight that whilst there are many excellent care and support services available in the City they are not always working well in terms of an overall system of care centred around keeping people well at home.**
- **A City wide Carers Survey undertaken in November 2012 identified 3 key areas for improvement:**
  - **Increase in social contact for carers**
  - **Better and more accessible information and advice**
  - **More respite options**
- **The Adult Social Care City Summit Event "Have Your Say" was held on 11 June 2013. This was attended by 80 people across the city including those who use services, carers and interested citizens. Some key themes were identified including:**
  - **The need for different services working closely together**
  - **Choice and control in terms of directing care (for example through the use of personal budgets)**
  - **Information needs to be easy to access and understand.**
- **The City's vision for the Integrated Model of Care is described as part of the CCG's Annual Operating Plan for 2014/15 and 2015/16. A public event was held on 13 December 2013 attended by 59 people to gain feedback and input to shaping the plans. One of the workshops asked views on the development of integrated care and key themes were:**
  - **There was broad support for a more integrated model of care and in particular the need for a system of care co-ordination was identified.**
  - **There was potential to expand the role of the community & voluntary sector in terms of a partnership working with health and social care services in an integrated model of care**

Further Public consultation events and feedback mechanisms will be put in place as an integral part of the Plan to ensure that service user and carer views drive the

new model of care. **A Service User and Carer Reference Group is in the process of being established to co-ordinate the engagement activity for integrated care in the City. The group will include representation from a range of representative bodies, patients, service users and carers drawn from our Patient Participation Groups and Health Watch. Lead representatives from the Reference Group will be members of the Frailty and Homeless Implementation Boards.**

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Urgent Care Clinical Forum Terms of Reference	**The clinical forum that developed the vision for an integrated model of care for frailty.** TOR Urgent Care Clincial Forum.doc
Integrated Frailty Board Terms of Reference	**The Board that will take responsibility for scoping the vision in more detail and implementing the model of care** Integrated Frailty Board ToR 20 Jan 20:
Homeless Integrated Pioneer Bid	**A bid was submitted to be one of the Integrated Pioneer site to develop an integrated model of care for the homeless. Although we were not selected as one of the Pioneer sites, the implementation of the model will be one of the key work programmes that will form part of the Better Care Fund.** Homeless - Integrated Pioneer Bi
Adult Social Care Modernisation Board Terms of Reference	**This Board oversees the major developments for Adult Social Care and will link with the Integrated Frailty Board**

	ASC Modernisation Board Terms of Refer
Adult Social Care City Summit Event 11 June 2013 "Have Your Say"	**Summary Report Detailing Stakeholder Feedback from the Adult Social Care City Summit Event to discuss the future of Adult Social Care** City Summit report - June 2013.pdf
Service Map	**A map which shows graphically some of the range of community health and social care services currently available.** Frailty map.pptx
Doctor Foster Hospital Guide for Surrey and Sussex	**An annual publication that highlights issues of NHS performance. It includes comparative analysis of emergency admissions to hospital.** Dr Foster Guide.pdf
Protection for Adult Social Care	**Report to Health & Well Being Board September 2013 detailing areas of spend on the NHS transfer to Adult Social Care** \HWB Board report on social care allocati
Community Short Term Services Service Specification	**Six local providers[3] of services work in an integrated way to deliver community short term services in the City** Community Short Term Services Service
Integrated Primary Care Team Service Specification	Integrated Primary Care Teams are multi-disciplinary teams that provide pro-active care to people with long term conditions

[3] Sussex Community NHS Trust, Brighton and Hove City Council, Brighton and Sussex University Hospital Trust, Age UK, Integrated Care 24 and Victoria Nursing Homes

	and/or who are frail. The focus of teams is to keep people well at home and avoid emergency admissions to hospital. IPCT Service Specification Jan 201
Better Care Plan : Report to Health & Wellbeing Board February 2014	Brighton & Hove Wellbeing Board Repc
Ageing Well chapter of the 2013 JSNA	The 2013 JSNA highlighted the need to raise the profile of older people in the City and develop a joined up approach to service provision that places older people firmly at the core and emphasises prevention and early intervention JSNA Ageing Well chapter 2013

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The vision for our frail population is to help them stay healthy and well by providing "whole person care", promoting independence and enabling people to fulfil their potential. Services will be seamless and co-ordinated. They will be delivered at home or in community settings wherever possible, avoiding unnecessary attendances at A&E, admissions to hospital and to long term care. Services will offer more choice and more flexible support to enable a more person centred approach. Organisations will work together to achieve better outcomes for people, and make the best use of available resources

The vision is based on the following principles:

1. Supporting people to stay well
2. Supporting carers
3. Encouraging people to maintain their independence;
4. Care built around the person, based on need and accessible 24/7;
5. A coordinated, proactive, preventative approach
6. The ability to respond quickly and flexibly when people have a change in need

There are a number of factors that will enable us to deliver the vision:

- **The Community & Voluntary sector will play an active role in supporting people to stay well**
- **There will be an emphasis on reabling care, including the use of assistive technology to support people to maximise their independence.**
- **People will be empowered to direct & personalise their care and support based on their individual needs.**
- **GP Practices will be at the heart of co-ordinating people's care with support from a multi-disciplinary team**
- **Care will be co-ordinated in a single place to ensure service users and carers only need to tell their story once. This will be supported by electronic sharing of data with all involved in providing care.**
- **Care Co-ordinators will take responsibility for active co-ordination of care for the full range of support (from lifestyle support to acute care)**
- **Service users and their carers will be listened to and drive the model of care**
- **Access to professional support will be available 24/7**

Within Brighton and Hove we have some excellent examples of integration between health and social care, for example multidisciplinary hospital discharge

teams, community short term services, mental health and dementia services and multi-disciplinary, multi-agency, integrated primary care teams. However, at a system level services are fragmented and do not always address the holistic needs of an individual. Previous mapping and consultation work has also identified that the system is not well set up for individuals who have multiple or complex needs. Not all community services are available 24 hour a day 7 days a week & in addition the complex web of services mean that it is not always clear which service or organisation should be accessed. We know this sometimes means that people attend A&E and are admitted to hospital as these are services people are familiar with and are generally known to be available 24/7. However these services do not always provide the best outcomes for people in that they can often reduce rather than increase independence. There is scope to provide more pro-active community care in an integrated way to support people staying well as well as providing a quick response in a crisis.

The proposed changes in the Care Bill will align with the outlined Vision: Importance will be placed on improving people's overall wellbeing, which shifts the emphasis to a system which promotes preventive and supportive measures. Other aspects of the Bill including better advice and information, consideration of the support needs of wider communities and legal entitlement of informal carers will support the need for a more coordinated and integrated way of working

In the future, it is our intention that the model of care around frailty will look very different. GPs (as the profession with responsibility for co-ordinating care around elderly frail) will be supported in their role by a multi-disciplinary team (MDT) wrapped around clusters of practices. In order to develop this MDT we will build on the Integrated Primary Care Teams (IPCTs), embed them more with Practice staff and extend their scope to cover all frail people registered at those practices.

We will increase the capacity and skill mix within the integrated teams and extend the membership of the multidisciplinary team to consistently incorporate mental health/substance misuse and social care staff and facilitate a more formal involvement of independent care providers and the community & voluntary sector in the partnership. Links to other council colleagues will be developed (e.g. housing, public health, communities team) to make sure people receive a suitable response, and to make best use of the skills and resource in local areas

We will reshape the model of care by bringing relevant staff out from the acute setting and embed them in the community team so that their remit is to in-reach to hospital when people require an acute stay. These core teams based around clusters of GP Practices will have rapid access to specialist support when required. Each frail person will have a designated "care co-ordinator" drawn from within the Integrated team. Depending on the specific needs of the frail person the care co-ordinator could be from any profession within the MDT – including the third sector.

For specific cohorts of frail people e.g. homeless residents the model of care will be bespoke to their needs and may include greater use of out-reach models of care

and support with housing related issues. In order to facilitate this new model of working staff from a range of organisations will come together into one team with a single line management structure, shared patient records and single assessment processes. We have agreed with all our partners in the City that we will pilot this integrated model in 2014-15 around a cluster of GP practices in order to test out the model and ensure lessons learned inform the full roll out across the whole city in 2015/16.

A stakeholder event has been planned for early March where the details of the Integrated Teams and ways of working across the wider system will be finalised to inform the creation of the pilot.

In addition to the pilot during 2014-15 we will start to pump-priming the whole system organisational and infrastructure development required (for example development of integrated IT systems, use of new technologies as well as supporting staff and organisations with change management) in readiness for a fully integrated model of care from 2015-16 onwards.

The presentation to the Health and Wellbeing Board attached in section (e) details a case study - Rachel Smith - a 64 year old woman living in extra care housing. It describes the current organisation or care and support and a vision of how things would look when care structures are more fully integrated.

For the frail person at the centre of this new way of working it will mean in practical terms:

- **I am supported to stay well: Rachel will have access to coordinated community based services and activities to support her to maintain good physical and mental health. This will mean she is less isolated, and her quality of life will improve. Rachel will also receive better Information about how to stay well – Locally Brighton and Hove has implemented a website called 'It's Local Actually' that provides information on thousands of local services, clubs, activities that are close to where the citizen lives. The main emphasis is reducing social isolation and encourages the use of social activities.**

- **I am encouraged to maintain my independence: Rachel would be offered a period of intensive, re-abling homecare and identify suitable Telecare and other equipment and work with her to get used to a new way of managing her personal care to build her confidence and improve her level of independence.**

- **The care is built around me. Rachel will have a named GP and a Care Co-ordinator who will co-produce a care plan and co-ordinate all aspects of care and support with her. A single care record will be used by professionals and care workers who are involved in her care to ensure Rachel only ever has to tell her story once. There will be continuity of care and support seven days a week.**

- **<u>My health conditions are under control.</u> Rachel will be provided with simple devices (Telehealth/ Telecare) and support to allow her to self-manage on a daily basis.**

- **<u>I am supported in a timely way when my needs change:</u> The Care Co-ordinator will pro-actively ensure that services are in place that can be flexible to respond swiftly to Rachel's changing (e.g. if she has a fall)**

As a result of these changes Rachel feels more supported to stay healthy and well and confident in the care she is receiving in her community and home. Her condition is better managed and her reliance on hospital services including the A&E department is significantly reduced. If she does require a stay in hospital she will be supported to regain her independence and discharged as soon as they she is ready to leave with continuity of care managed through the "Care Co-ordinator".

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:
- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aim: To provide "whole person" care and support to people in their own homes and communities with care that:

- **Is co-ordinated around individuals and targeted to their specific needs**
- **Maximises independence by empowering people to manage their own health and wellbeing.**
- **Improves outcomes (for example a reduction in premature mortality for people with serious mental illness and improved quality of life e.g. better management of long term conditions)**
- **Enables quick recovery after periods of ill-health**
- **Improves the service user and carer experience**
- **Avoids unnecessary admissions to hospitals and care homes.**
- **Provides a responsive service 24/7**

To achieve this we will Pilot the Integrated Model with a cluster of GP practices and use learning from this to inform the full roll out across the City. This will include:

- **Building on the new requirement in the national GP contract from 1 April 2014 to provide a named GP for patients aged over 75 and those with complex needs.**
- **Investing in operational management infrastructure to oversee the management and organisation of care from the various providers**
- **Investing in Care Co-ordinator roles that take responsibility for organising**

care around the specific needs of the individual.
- Ensuring ability to respond to an individual's change in need in a timely and appropriate way
- Maximising opportunities for the independent care sector and the well-developed local community and voluntary sector to be an active partner in service delivery
- Working with public health and other council colleagues to ensure a joined up system of community support
- Working towards a single integrated care record

Aim: To improve the quality of the services received by the individual
- Individuals will have access to a team ensuring right care by the right person in a timely fashion
- There will be a reduced risk of delay in support and resulting harm by reducing hand offs
- There will be reduced incidents of harms (pressure injuries, falls, etc.) by facilitating access to professional advice and a continuum of support commensurate with fluctuating need
- Sharing of knowledge and skills across the traditional professional and organisational boundaries leading to a higher level of generic skills reducing the need to have multiple individuals to deliver care but insuring access to specialist advice when required
- Improved governance by sharing policies and procedures and improving clarity of responsibilities and accountabilities

<u>How we will measure these aims and objectives?</u>

We will work with colleagues in Public Health to quantify the benefits we should expect to see from more integrated care – including identifying measures of success as defined by our service users and we will evaluate the impact of our Pilot in achieving these.

<u>What measures of health gain will you apply to your population?</u>

Improved coordination of integrated care should result in an improvement in the following measures:

- Reduction in volume of emergency activity in hospitals – both hospital admissions and A&E attendances
- Reduced length of stay in hospital
- Reduction in volume of residential and nursing care placements.
- Improved service user and care satisfaction
- Increase in proportion of people feeling supported to manage their long term condition
- Increased diagnosis rates for people with dementia
- Improved quality of life – reported by service users and carers

The details of the metrics and trajectories are detailed in the Outcomes Section of this Plan.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

CCG and Adult Social Care Commissioning priorities already reflect an intention to support people to stay well, and where they do require health or care services, there will be an emphasis on making best use of current resource to maintain independence. Achievement of the vision will require significant change across all current health and social care providers.

GP practices will need to further develop collaborative arrangements with neighbouring practices to ensure services can be provided consistently and at sufficient scale to make them economically viable. They will play a central role in the co-ordination of care and to achieve this they will need to develop greater more formal multi-disciplinary team working arrangements with other health and care organisations.

All providers of care will need contribute to the development of integrated teams aligned to GP Practice. This will mean that all providers of care and support will need to ensure that their systems can link to deliver integrated care to individuals

From a commissioning perspective the CCG and BHCC will need to further develop integrated commissioning arrangements as well as develop more innovative approaches to commissioning and contracting of integrated models of care that aligns financial incentives to improved outcomes.

Key Stages

1) **December 2013. Recruitment of Joint Programme Manger to work across the CCG and the Local Authority to support the implementation of the integrated models of care**

2) **January to March 2014. Diagnostic Scoping Work to identify the target population to be included.**
   - **At minimum this is expected to cover the estimated 5% of the population (15,000 people) with multiple, often complex mental or physical long-term conditions often compound by being elderly or frail**
   - **It may also include some or all of the estimated 20% of the population (60,000 people) with a moderate mental or physical long term condition who may benefit from a more co-ordinated approach to their care.**

3) **April 2014 to March 2015 – Strengthen Existing Service Provision** **specifically:**
   - **Investment in capacity of integrated teams**
   - **Investment in primary care and step down facilities for homeless care;**
   - **Establishment and Roll Out of Personal Health Budgets**
   - **Increased 7 Day a Week Working**
   - **New GP contract for patients aged 75 and over and for those with complex needs to have a comprehensive and co-ordinated package of care via an accountable GP.**

4) **April 2014 onwards – Pilot the Integrated Frailty Care Model with a cluster of GP practices.**
   - **Investment in multi-disciplinary team operational management structure**
   - **Care Co-ordinator Roles introduced**
   - **Maximise role of the Independent care sector and the Community and Voluntary Sector in partnership working in delivering care**

5) **April 2014 onwards – Support for Transformational Change**
   - **Invest in organisational development support for front line staff**
   - **Organisational Development Programme for Senior Leaders (commissioners and providers) through NHS IQ**
   - **Invest in IT infrastructure to create single record**
   - **On-going feedback from service users to drive service model**

6)From April 2015
   - **Evaluation of the pilot to inform Full Roll Out of the Integrated Care Model**

The plan has been developed jointly between BHCC and CCG and priorities for investment have been based on the local needs of our population. In particular the approach to frailty is not just about older people but will include a variety of population cohorts with complex needs that could benefit from more integrated care.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

It is anticipated that providing more integrated and pro-active care in the community will reduce the need for hospital based emergency and planned care. At a national level it is expected that hospital emergency activity will reduce by about 15% as a result of the development of Integrated Care. (NHS England (2013) Everyone Counts Planning for Patients 2014-15 to 2018-19)

However Brighton and Hove already has a comparatively low rates of emergency hospital admissions, we are in the lowest quintile nationally for non-elective

admissions and for non-elective admissions for primary Ambulatory Care Sensitive conditions therefore limiting the scope for further savings. More detailed data analysis is detailed in section e of this report. The total expenditure on non-elective admissions and A&E attendance for Brighton and Hove residents and Brighton and Sussex University Hospital Trust is £4.2 million. It is estimated that a further reduction of 10% on our current baseline could be realised. We also expect that by more proactive management of people with complex needs and long-term conditions we can avoid a number of elective procedures and realise efficiencies from working in a more integrated way across acute and primary/community care.

We therefore expect a saving of between £8.3 and £10m to be realised from current spend, the majority of which will be in the acute sector.

If we do not see the impact of more proactive integrated community provision on the acute sector immediately we do have a contingency reserve to cover the risk over a longer transition period.

e) Governance

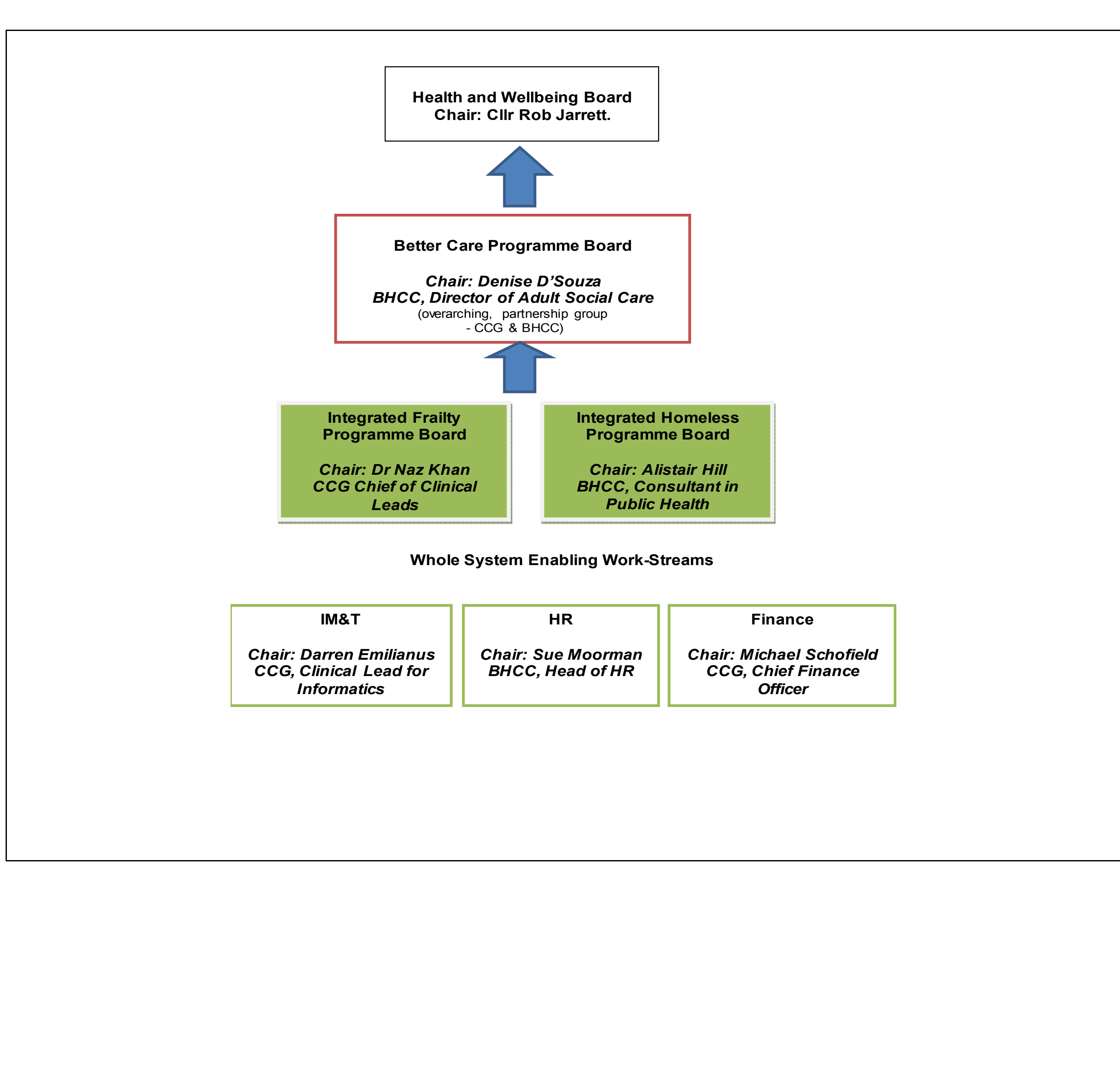
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

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

A Better Care Programme Board has been established to oversee the Better Care work programmes. Its main purpose is to provide system wide leadership and accountability for delivery of the Better Care Agenda across Brighton and Hove health and care economy. Overseeing the work of the various Integration Programme Boards the Better Care Programme Board will ensure the vision and requirements of Better Care are implemented. The Brighton Better Care Programme Board is accountable to the Brighton and Hove Health and Wellbeing Board.

The Adult Social Care Modernisation Board will also include consideration of the Better Care Programme and will ensure that the work undertaken in response to the introduction of the Care Bill links to the Better Care Programme Board. Sub Groups of the Modernisation Board will ensure they consider links and overlaps.

Implementation Boards for Frailty as well as a specific Board for Integrated Homeless Care will report in to the Better Care Programme Board. Whole System Enabling Work-streams for IM&T, HR and Finance will support the overall programme. The governance structure is detailed below.


Health and Wellbeing Board
Chair: Cllr Rob Jarrett.
Better Care Programme Board
Chair: Denise D'Souza
BHCC, Director of Adult Social Care
(overarching, partnership group
- CCG & BHCC)
Integrated Frailty
Programme Board
Chair: Dr Naz Khan
CCG Chief of Clinical
Leads
Integrated Homeless
Programme Board
Chair: Alistair Hill
BHCC, Consultant in
Public Health
Whole System Enabling Work-Streams
IM&T
Chair: Darren Emilianus
CCG, Clinical Lead for
Informatics
HR
Chair: Sue Moorman
BHCC, Head of HR
Finance
Chair: Michael Schofield
CCG, Chief Finance
Officer

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Protecting Social Care services in Brighton & Hove means ensuring a focus on supporting the most vulnerable people in the city. Safeguarding Adults remains priority. Where people do require services, there is an emphasis on short term reablement services to enable them to fulfil their potential. In the context of growing demand and budgetary pressures, new and innovative approaches will be required to support people with their care needs. Increasingly, people are purchasing their own care services using their personal budgets and so different solutions will need to be available for them. The eligibility criteria for services will not change, but there will be an emphasis on preventive services that help keep people healthy and well. The local plan for Brighton & Hove includes:

- **Maintaining current eligibility criteria for adult social care services**
- **a continuation of existing services such as early supported discharge and rapid response services**
- **spending on adult social care to maintain essential services**
- **investments in new services such as additional staffing for bed based short term care services**
- **a joint winter contingency the proposals for which will be jointly agreed by health and social care and used to provide additional investment in core services to mitigate winter pressures.**
- **Support for the independent care sector to ensure timely discharge form hospital**
- **To develop a flexible funding resource that would enable health and social care providers to respond effectively in a coordinated way to changes in demand across systems**

However the vision for the future 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.

By pro-actively supporting people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own care wherever possible in their own homes this enables a better use of overall resource.

Please explain how local social care services will be protected within your plans.

All of the funding currently allocated in 2013-14 under the Social Care to Benefit Health Grant has been maintained to enable Brighton and Hove City Council to maintain the current eligibility criteria to provide:

- **Timely assessment**
- **Care management to facilitate timely discharge from hospital**

- **Service delivery to people who have substantial or critical needs**
- **Information and Sign-posting to those who are not eligible for ASC services**
- **Funding services in the Community & Voluntary sector**
- **Services with a reablement focus**
- **Increase the number of assessments**
- **Further investment in rehabilitation/re-ablement (including Telecare) to reduce hospital admissions and admissions to residential and nursing home care**
- **Support for carers**
- **Additional home care support to facilitate hospital discharge**

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Many of the health and social care services to support hospital discharge are available 7 days a week. This includes:

- **Integrated Primary Care Teams (IPCT's) that provide pro-active care keeping people well at home**

- **Community Short Term Services (CSTS) that provide rapid assessment and time-limited support to:**
  - **Prevent avoidable hospital attendances and/ or admissions;**
  - **Support service users to recover from a spell of illness/injury following a stay in acute hospital; and**
  - **Maximise a service user's independence through rehabilitation and re-ablement**

- **Brighton Urgent Response Service and Crisis Resolution Home Treatment Team for people with urgent mental health needs**

- **Living Well with Dementia Service – that provides a 7 day a week service including crisis response**

- **Independence at Home - the council's home care service**

In addition to maintaining the 2013/14 levels of funding further investment has been made in 2014-15 to Deliver 7 Day Services in Adult Social Care

All of the services are commissioning jointly between the CCG and BHCC and provided jointly by health and social care and community and voluntary sector providers.

Additional funding has been made available in the Winter of 2013-14 to facilitate 7 day services in health and social care and this will be consolidated within the Better Care Programme, this includes:

- **General Practice Pop-Up Clinics Available at Weekends and Bank Holidays**
- **Additional Capacity in Community Short Term Services**
- **7 Day Week Medical Consultant Support in Dementia Services**
- **Safe Space in the Council where homeless people can go extended to 7 day working**

This learning from this winter will be used to assess how successful the additional resource has been in terms of facilitating discharges from hospital and reducing avoidable emergency admissions and enable the CCG and BHCC together with partnership organisations to assess what additional capacity is required on an on-going basis.

In addition to this plans are for:

- **Additional Therapy Capacity in IPCT's**
- **Additional Therapy Capacity in Community Short Term Services to enable 7 day a week working including a dedicated ambulance**
- **Incentivise home care providers and care homes to enable more timely discharge over 7 days, and to put support mechanisms in place for them to respond to requests effectively.**

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence.
The Council system (OLM Carefirst) has the functionality to include the NHS number but the current primary identifier is the Carefirst number. Current performance is that approximately 52% of people using services have their NHS number on the Carefirst system.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The Council is committed over the next year to a programme that will ensure the NHS number is provided on the system along side the Carefirst number as a primary identifier. Currently this is being progressed through ;

1. The opportunities provided through the Zero Based Review which will go live on 1/4/14 to promote the use of the NHS number within services.
2. Discussions with systems providers that would support a full data collection re the NHS number.
3. Exploring opportunities within integrated services to support the NHS number being used as a primary identifier, and the programme within this document will support this work
4. Developing regular performance reporting that will monitor performance re use of the NHS number across all services and which can be used within our data quality programme.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems based upon Open API'S and Open Standards.

During 2014/15 our 47 GP Practices will begin to upgrade to GPSoC-R products which have Open APIs (dependency on HSCIC to deliver capability) on which multiple suppliers can build record viewing and remote recording solutions.

Multi agency record viewing systems are currently being explored.
We are also deploying Clinical Correspondence projects to handle GP->Provider correspondence utilising open standards such as ITK. XML, Coded and Non-Coded CDA.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott2.

We have an established Information Governance framework and we are committed to maintaining five rules in health and social care to ensure that service user confidentiality is maintained. The rules are:

- **Confidentiality and information about service users should be treated confidentially and respectfully**
- **Members of a care team should share confidential information when it is needed for the safe and effective care of an individual**
- **Information that is shared for the benefit of the community should be anonymised**
- **An individual's right to object to the sharing of confidential information about them should be respected**
- **Organisations should put policies, procedures and systems in places to ensure the confidentiality rules are followed**

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Risk stratification of practice population is a core element of the Integrated Primary Care Team delivery model which is currently supported by the Risk Profiling and Case Management Directed Enhanced Service that profile the top 2% of patients most at risk of emergency hospital admission.

Each GP practice identifies individuals at risk of admission using a predictive tool (the urgent care clinical dashboard) and organises multi-disciplinary team meetings inviting the relevant community practitioners from health social care

(both physical and mental health). An action plan is produced for each patient discussed and where a patient is identified as suitable for case management a lead professional is be identified. This could be a member of the practice team or IPCT, as appropriate to each individual patient.

This approach to joint assessment and care planning will be built upon and extended as more integrated models of care are developed.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	**Risk rating**	**Mitigating Actions**
Ability to transfer resources from acute sector to fund new integrated models of care within the required timescales	High	CCG non-recurrent funding available to support transformational change
Buy in From Front Line Staff to deliver Integrated Models of Care	Medium	Full sign up from senior level across all partners. Organisational Development Support key part of the Better Care Plan Comms strategy being developed jointly across all agencies.
Providers not able to make required workforce changes in relation to capacity and capability	Medium	The Better Care Programme Board will work with providers and oversee the development of an integrated workforce plan.
IM&T- ability to create a single care record to support the service change	Medium	Establishing a multi-agency IM&T Group to oversee the whole system adoption of a single care record
Length of Time to Implement Changes – given complexity of change and wide range of organisations involved	High	Agreed to Pilot First – Phase 1 of the Plan to ensure learning prior to full roll out.
Uncertainly for Adult Social Care in relation to the cost pressures of the Care Bill and how this will impact on investment plans	High	Adult Social Care Modernisation Board will review investment plans for the Care Bill and for the Better Care

Competing demands for Adult Social Care to implement the Care Bill, the Modernisation agenda and the reduction in the council's budget	High	Development of an integrated plan to include competing priorities
Continued pressure on hospital and lack of community response may lead to an increase in nursing home placements	High	Development of coordinated robust community services to respond to demand.