



Integration and Better Care Fund

Narrative Plan Template 2017/19

Better Care Support Team

Area	South-East
Constituent Health and Wellbeing Boards	East Sussex
Constituent CCGs	Eastbourne Hailsham Seaford CCG Hastings and Rother CCG High Weald Lewes Havens CCG



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General

This template is a guide to help you to draft a BCF narrative plan for your area. You do not need to use this template or follow this structure but it has been provided to assist areas to cover all the requirements for the BCF in their narrative plan.

Your narrative plan should build on approved plans from 16/17, demonstrating that local partners have reviewed progress and used this information in developing plans for 17/19. The template will be complemented by the planning template, which has been circulated to all areas, and should be completed with reference to the BCF Policy Framework and Planning Guidance. Local areas are also advised to use the key lines of enquiry (KLOEs) that will be used to assess the BCF narrative plans.

Please refer to the notes section below for each section for brief guidance on what to include in each section. Areas can use more than one page for each section and add diagrams and tables where helpful.

The BCF narrative plans must set out:

- The local vision and model for the integration of health and social care;
- A coordinated and integrated plan of action for delivering the vision, supported by evidence;
- A clear articulation of how the plan meets each national condition; and
- An agreed approach to performance and risk management, including financial risk management

Please note that referencing and use of hyperlinks to existing documents is advisable rather than copying content into your narrative submission. However, please try to signpost documents as comprehensively as possible e.g, include the citation reference (e.g page number and relevant section).



Introduction / Foreword

The East Sussex 2017-19 plans for the Better Care Fund build upon the 2016/17 BCF plans and outline how we will deliver against the 4 national conditions defined within the Better Care Fund Policy Framework and the Integration and Better Care Fund Planning Guidance for 2017-2019.

These plans should be read alongside the Sussex and East Surrey Strategic Transformation Plans (STP) and the five year strategic investment overviews which inform longer term strategic planning for each of the CCGs in East Sussex.

There are 2 Transformation Programmes in place across East Sussex, led by the key partners to the Better Care Fund Plans:

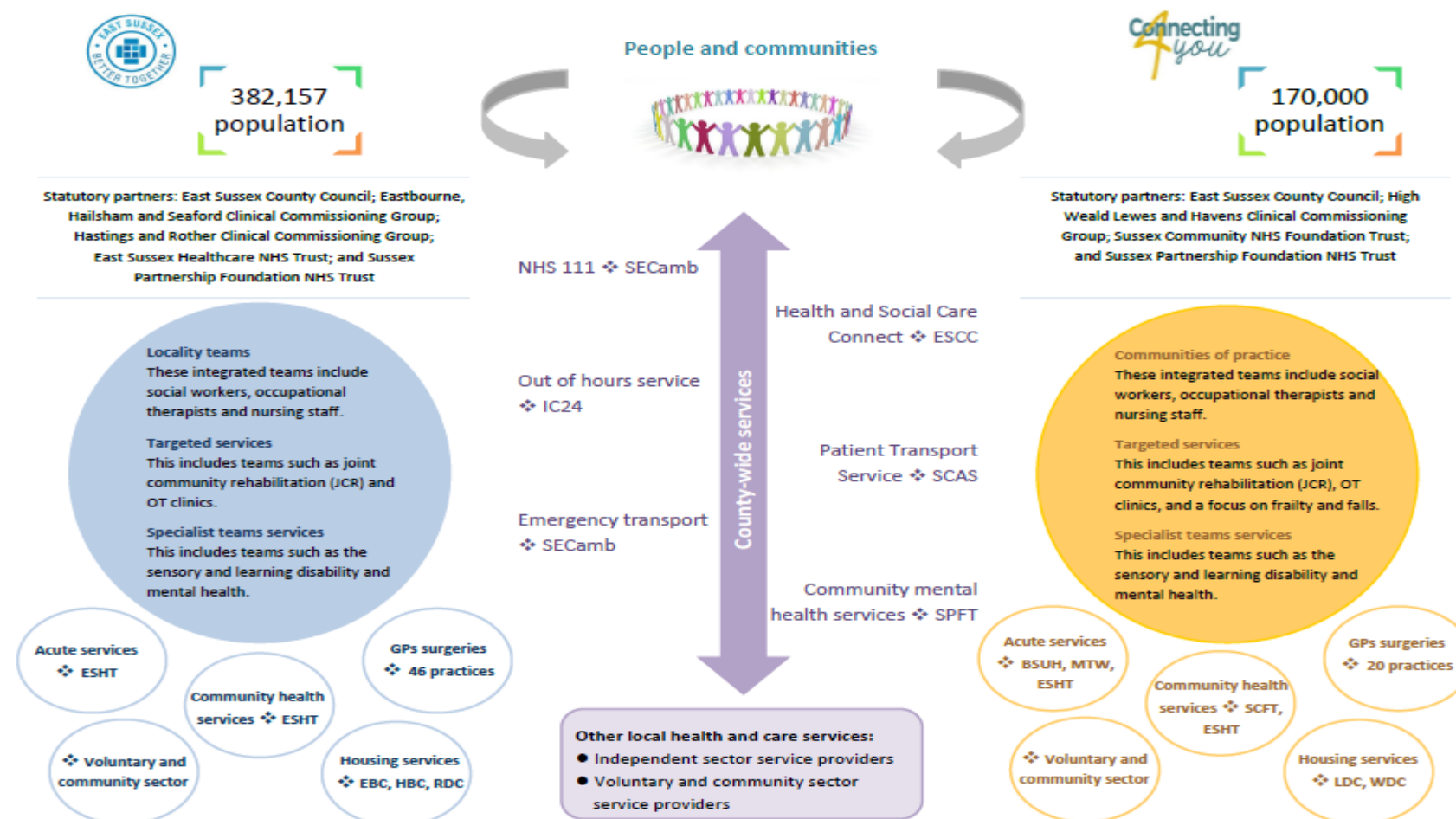
- East Sussex Better Together (Eastbourne Hailsham Seaford CCG and Hastings and Rother CCG areas)
- Connecting 4 You (High Weald Lewes Havens CCG area)

The East Sussex Better Care Plans outline a wide range of schemes which have been agreed to support the agreed strategic ambitions of these transformation programmes which focus on:

- Ensuring that every patient and client will enjoy proactive, joined-up care that supports them to live as independently as they can and achieve the best possible outcomes
- Keeping people as well as possible and helping us to act quickly when they become unwell or require help
- Ensuring people have access to the services when and where they need them
- Helping people stay in or close to home and minimise hospital admissions
- Ensuring our services are effective and affordable

Health and social care services for Adults in East Sussex

The graphic below illustrates how health and social care services are organised in East Sussex:



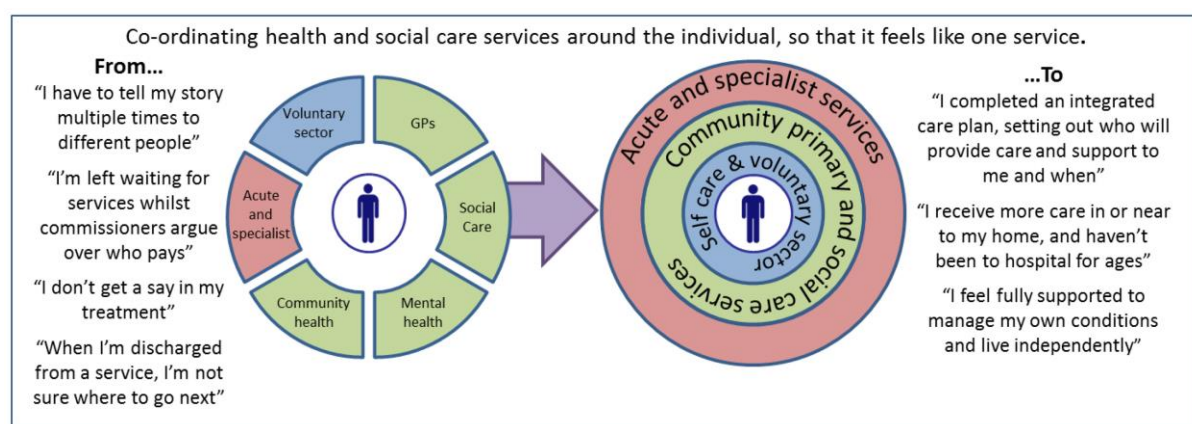
What is the local vision and approach for health and social care integration?

Our shared vision is that by 2020, there will be a fully integrated health and social care economy in East Sussex that ensures people receive proactive, joined up care, supporting them to live as independently as possible and achieving the best outcomes. This includes strengthening community resilience through an asset-based approach that enables local people to take ownership of their own health and well-being through proactive partnerships. Ultimately by working together we aim to achieve high quality and affordable care now and for future generations and improve the safety and quality of all the services we commission and deliver.

Alongside this, our vision is to create a sustainable health and social care system that promotes health and wellbeing whilst addressing quality and safety issues, in order to prevent ill health and deliver improved patient experience and outcomes for our population. This will be delivered through a focus on population needs, better prevention, self-care, improved detection, early intervention, proactive and joined up responses to people that require care and support across traditional organisational and geographical boundaries.

We have been working together as commissioners and providers across the East Sussex health and care economy for some time to refine our shared vision. We recognise that we cover a large geographic area and that the needs of our communities differ. We also recognise where we need to act together to deliver meaningful improvements in outcomes in response to local need and what our residents have told us is important to them.

Our transformation plans reflect our commitment to developing services which are co-ordinated around individuals as illustrated in the BCF Policy Framework 2017-19.





Alignment with Sussex and East Surrey STP:

The Sussex and East Surrey foot-print shares the challenges and opportunities of the rest of the country in delivering the triple aims of the STPs, with particular challenges locally due to our population demographics

The aspirations for longer term transformation and delivery of the Five Year Forward View will be driven by 4 'places' – each aiming for an accountable care model and an agreed focus on key areas as an STP.

These priorities are reflected in the ESBT (one of the 4 'places' within the STP) and C4Y (part of the Central and East Surrey Are South 'place') transformation programmes which the East Sussex Better Care Fund supports.

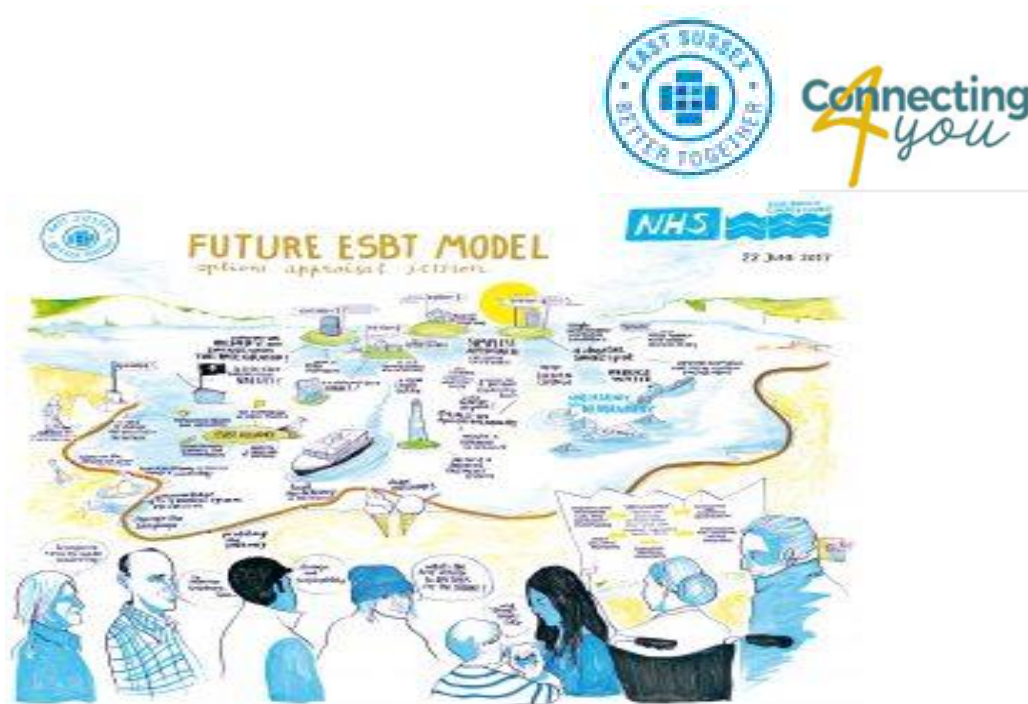
East Sussex Better Together

East Sussex Better Together (ESBT) is a whole system (£1billion) health and care transformation programme, which was formally launched in August 2014, to fully integrate health and social care across the ESBT footprint in order to deliver high quality and sustainable services to the local population.

ESBT is a partnership comprising Eastbourne Hailsham and Seaford (EHS) Clinical Commissioning Group (CCG), Hastings and Rother (HR) CCG and East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT) and Sussex Partnership NHS Foundation Trust (SPFT). The programme covers a population base of approximately 370,000.

ESBT have a combined resource of £1.042billion, the majority of which is used to commission primary, community, acute, mental health and social care services from East Sussex NHS Trust (ESHT), Sussex Partnership Foundation Trust (SPFT), GP Practices and providers in the independent care sector and voluntary sector.

The ESBT Alliance partners, Eastbourne Hailsham Seaford (EHS) and Hastings and Rother (HR) Clinical Commissioning Groups (CCGs), East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT) and Sussex Partnership Foundation NHS Trust (SPFT) have agreed to a formal Alliance Agreement to underpin our arrangements for 2017/18, allowing room to test to best effect what will be the right solution for the people we serve and deliver the best outcomes for our population.



http://news.eastsussex.gov.uk/east-sussex-better-together/wp-content/uploads/sites/10/2017/07/East-Sussex_Options-Appraisal-Session_22-06-17_LR-300x259.jpg

To lay the foundations for success in 2017/18 we have:

- Commenced the alliance arrangement, including adoption of an Alliance Agreement and a new integrated governance structure
- Taken our collaboration to new levels to further improve and deliver services, test the new approach and understand the impacts through putting in place integrated operational and performance management across our system.
- Agreed our integrated medium term ESBT Strategic Investment Plan (SIP) and schemes for 2017/18, together with a single system-wide financial 'real-time' reporting framework to support the operational performance of the system.
- Started the process for appraising the available options for organisational form for the future ESBT accountable care system after the 2017/18 transition year. A preferred option will be agreed by our individual sovereign commissioning organisations in July 2017 (informed by our providers), together with an indication of what the staff arrangements are likely to look like, and a roadmap for implementation.
- Developed an integrated outcomes framework so we can measure how well our system is delivering for local people; this has been informed by what local people have told us is important to them and ensures a focus on key national priorities too.
- Developing a formalised risk share arrangement across the full alliance partners to incentivise a culture and practice of improvement and a significant move towards a system control total.
- Delivered (and continue to deliver) engagement with our local population, staff, GPs and our partners in the wider health and care system to ensure stakeholders have an



opportunity to contribute and inform discussions and the final recommendations on preferred legal vehicles for commissioning and delivery in July.

- Established an ESBT Clinical Leadership Forum comprising primary and secondary care clinical leaders to drive the delivery of integrated care pathways and lead the necessary behavioural change in support of this.
- Established an ESBT Public Reference Forum, delivered via our local Healthwatch, to complement existing engagement mechanisms by drawing on a wider, less traditionally engaged population base to inform our plans on every step of the way.
- Begun to co-design (with local people) a health and care collaborative to ensure voluntary sector and local involvement in our strategic planning and a voice within our integrated governance structure.
- Committed to invest circa £1.3m over a two-year period in our primary care federations to support at scale primary care transformation and deliver the ambition of the GP Forward View whilst ensuring a delivery platform that can, over time, offer a strong interface as allied partners to our alliance.
- Implemented a Healthy Hastings and Rother programme, investing £5m year on year to tackle the most entrenched healthy inequalities in our area.
- Invested in increasing the capacity of community services and Health and Social Care Connect or single point of access to care services.
- Implemented a fully asset-based approach to community resilience in a true partnership with our local voluntary and community sector.

As our place-based system, ESBT is in a strong position to implement fast progress in delivering the service improvements described by the Five Year Forward View Next Steps plan around urgent and emergency care, general practice, mental health and cancer care, by implementing a prevention-led approach that contributes to the Sussex and East Surrey Sustainable Transformation Plan (STP). Our alliance is helping us make decisions for the collective good of our system and the people we serve.

In July 2017, the following steps were agreed by the ESBT partners to accelerate implementation of a strengthened ESBT Alliance arrangement by April 2018:

- moving towards single leadership, governance and management of our commissioning resource by April 2018 (including exploring a single pooled budget for our health and care economy)
- moving towards single leadership of the delivery function and how services are organised by April 2018
- seeking an integrated approach to regulation
- strengthening performance and monitoring against our integrated Outcomes Framework

ESBT Outcomes Framework

The 2017/18 test-bed year is designed to enable oversight of the whole health and care system from both a commissioning and delivery perspective, supporting us to act collectively in a way that delivers improvements for our local population. In addition it also creates a collaborative learning environment in which we can progress the development work to design our final proposed ESBT Alliance system of accountable care.

Building on our original ESBT work on reporting progress against population health and health inequalities outcomes, an integrated Outcomes Framework has been developed to inform our stakeholders about progress made across the health and social care system on delivering improvements to population health and wellbeing, experience, quality and sustainability – including the per capita cost of care.



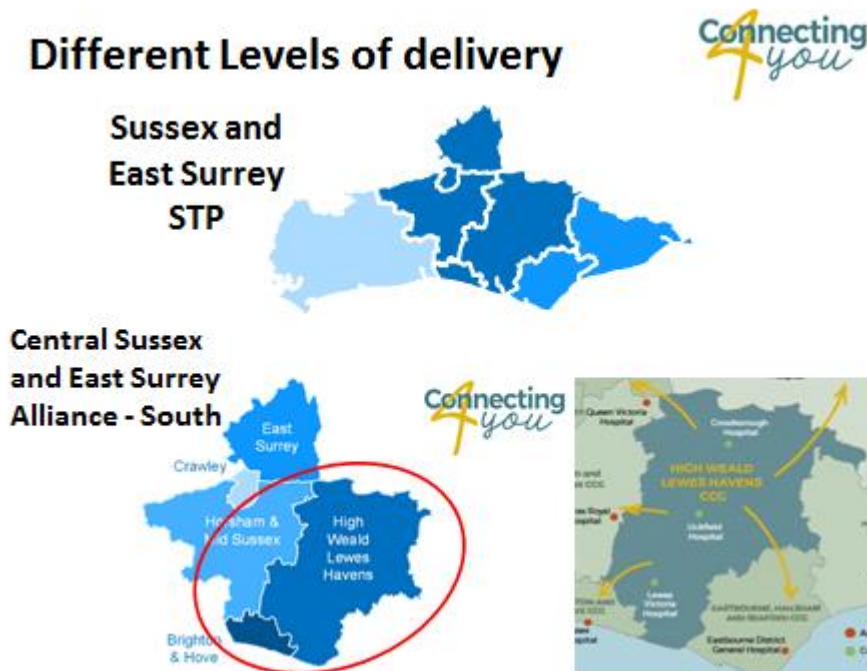
Further information can be found at <http://news.eastsussex.gov.uk/east-sussex-better-together/stakeholders/monitoring-and-evaluating/>

Actions to support delivery

- Specific targeted actions : intervention level
- Locality Planning and Delivery : Establish six P&D Groups across the ESBT footprint
- Oversight and delivery : Establish weekly Executive Oversight group / Integrate PMO
- Understand demand and cost base issues : Drivers for demand / Case mix / tariff inflation / CIP
- Pathway / service redesign: E.g. Agree and implement rehabilitation strategy & integrated frailty pathway
- Workforce : Including role development – Integrated Support Workers / GP fellowships etc. & international recruitment

Connecting for You

Connecting 4 You (C4Y) is a joint programme to transform local health and social care services in the High Weald, Lewes and the Havens area. The programme supports the local delivery of the Central Sussex and East Sussex STP 'place' plans.



C4Y is a transformation programme to meet the specific needs of the HWLH population and to:

- Develop and introduce a new 'community model of care' for HWLH
- Develop 'system leadership', allowing leaders across the HWLH health economy to:
- Oversee and monitor the 'whole system' of activity
- Hold the system and each other to account for delivery

This will be achieved through an approach to integrated care which is population based and agreed between commissioners and providers:

C4Y is represented at the E Sussex Health and Housing Sub Group through which strategic developments agreed and resulting initiatives identified. Representation from Lewes District Council and Wealden District Council at C4Y Programme Board and C4Y Operational Delivery Group with remit to ensure housing issues considered.



There is agreement that the C4Y Board will be notified of all new planning applications for ALL new housing, residential provision and the like to ensure that health and social care impacts will be fully considered.

C4Y Programme Plan is being developed and will include all inter-dependencies with other programmes within CCG, ESCC and provider organisations.

Further details of the C4Y governance are included on Page 40

Connecting 4 You (C4Y) is a transformational programme and it has been determined that this is best delivered by the adopting the Multispecialty Community Provider Model (MCP). It is perceived that this will allow the flexibility to both progress the four 'communities of practice' and to develop the best fit model to deliver accountable care across the region. Given the complex geography across HWLH, not least the fact the area is served by four acute hospital trusts, the decision was made to initially adopt 'Virtual' MCP model. However this may progress towards a more formally integrated status over time. It was also agreed that a focus of 'frailty' should be the priority for 2017-18 across HWLH. Not only is this identified as a cross cutting priority for all of the organisations represented it was also seen as an ideal opportunity to develop the new ways of integrated working within HWLH.

The key priorities for the C4Y programme are:

- Coordinated prevention and self-management
- Single/'streamlined' point of access
- Integrated community NHS and social care teams
- Joint urgent out-of-hospital care approach and interface with locality work
- Strategy for accommodation and 'bed based' care: Community Hospitals and nursing/EMI care homes
- Joint mental health strategy (including Dementia)
- Review children's services: SEND; services for autism; role of community paediatricians; CAMHS; etc.
- Plan workforce and capacity
- Joint / integrated planning/locality planning

These are further illustrated in the C4Y community model of care illustrated below:



C4Y Capacity and resilience plans to support delivery of the C4Y objectives:

There is a work-stream governed by the C4Y Strategic Planning and Investment Group to produce an Aggregated Financial View for HWLH. Initial tasks include understanding the collective resources deployed over the whole of the HWLH patch. This will then be distilled down to each of the four Communities of Practice at a progressively granular level in order to provide the intelligence required to drive strategic decisions in regards to demand, capacity and resilience.

Population profiles, CoP specific JSNAs, current service delivery and community teams and assets will also be overlaid to develop a comprehensive picture.

The use of a risk stratification system in the future will assist in the challenge of ensuring that financial contributions are allocated according to need.

By 2019-20 there needs to be clear strategic plans to reduce spend by realising preventative and system efficiencies.



C4Y Outcome measures

Outcomes will be monitored by the use of a Risk Stratification Tool that is currently being identified. This will allow detailed analysis, both on a population and individual patient level, of the impact of programmes and projects in terms of improved outcomes for the individual and overall benefit to the health and social care economy for HWLH.

All service specifications include quality and outcome measures/metrics

Use of established Outcomes Frameworks with reporting via dashboards, e.g. Public Health and NHS Outcomes Frameworks

How does the BCF help to achieve all of the above?

The Better Care Fund provides the opportunity to strengthen our unified approach outlined in the ESBT and C4Y programmes and to ensure delivery of “excellent sustainable services with a local focus” We have committed much of our leadership energies as a system to delivering these programmes, working through them consistently since the Clinical Commissioning Groups in our area were formed.

We have worked and will continue to work with partners and local people to develop our plans for the next five years:

- We have already undertaken a wide ranging programme of engagement with system stakeholders to develop our approach which includes care design groups, shaping health events and partnership boards
- Building on this we are committed to involving our partners and local people in shaping future services. We need to have an open and honest conversation about how we can meet the challenges that we face. We need to make sure that we do what is best for the population of East Sussex as a whole.
- We continue to involve our partners and local people in developing our overarching approach to make sure it is right first, before we begin developing more detailed implementation plans with them, to ensure that they reflect and meet the needs of the distinct populations served by each commissioner.



Background and context to the plan

Our integrated approach is based on a set of key principles and our shared commitments to:

- Deliver wholesale change – we are adopting a phased approach to delivering the changes required;
- Build on evidence about what works – both learning from our experience locally, as well as from elsewhere (nationally and internationally);
- Develop services based on a ‘You said, we delivered’ approach;
- Deliver consistently high quality services and outcomes across the county – with locality based delivery solutions based on local need;
- Invest in community and primary care as the keys to shifting finite resources out of acute care; and
- Use a phased approach – including using the Better Care Fund (BCF) as one of our key mechanisms for delivering high quality, safe and sustainable care at scale and pace.

Local demography and future demographic challenges

The East Sussex population is projected to increase by nearly 34,000 to 578,000 between 2015 and 2030 (6.2%). Population growth over the period will mostly be among the over 60s as the population continues to age. The average (median) age of East Sussex residents will rise to 50 years and 9 months in 2030; from 45 years and 11 months in 2015 (England 2015 average is 40 years).

Currently, the over 65s represent a quarter of the county’s population. This is projected to increase to one third by 2030. All elderly age groups are expected to increase in size, with the number of very elderly people aged 85 and over expected to increase by 83%, from around 21,300 in 2015 to 38,900 in 2030. In Rother, the elderly population is expected to make up 40% of the population in 2030.

There will be a decline in the working age population (18-64) of over 6%. This decrease will be concentrated among younger people aged 20-34, partly due to lower levels of net migration. The fall in the number of middle-aged people aged 45-54 is due to a decline in fertility rates after the baby booms.

Over the period 2015-2030, the number of households in East Sussex is likely to increase by 11.9%, which is twice as fast as the expected growth of the population of 6.2% for the same period. This is mainly due to a fall in the average number of people living in each household (household size) from 2.21 in 2015 to 2.08 in 2030.

The number of households headed by older people aged 65 and over is projected to increase by 37% by 2030. Single male households are expected to see a large increase of 24%, and couples with no dependent children living with one or more other adults (up 20%), reflecting predicted changes in how people will live, with more shared households and adult children staying with parents.

Further details can be found at:

Population estimates:

<http://www.eastsussexinfigures.org.uk/webview/index.jsp?catalog=http%3A%2F%2Fwww.eastsussexinfigures.org.uk%3A80%2Fobj%2FfCatalog%2FCatalog47&submode=catalog&mode=documentation&top=yes>

Population projections:

<http://www.eastsussexinfigures.org.uk/webview/index.jsp?catalog=http%3A%2F%2Fwww.eastsussexinfigures.org.uk%3A80%2Fobj%2FfCatalog%2FCatalog47&submode=catalog&mode=documentation&top=yes>

Local health and social care market

At present there are 6,402 care home beds in East Sussex: 3,441 residential care and 2,961 nursing care. The existing provision in East Sussex is running at occupancy levels of over 90%. High percentage occupancy causes inefficiency, inflexibility, and the inability/unwillingness of 'market' provision to manage more complex and staff-intensive cases. Higher levels of occupancy in areas where the level of supply is comparatively low (e.g. HWLH) exacerbates existing market inadequacy.

This increases pressure across the whole health and social care system and impacts on our ability to facilitate timely discharge from hospital. There is particular concern around nursing and dementia care beds, where demand continues to increase and the cost pressures facing the market continue. In addition, when care home placements are suspended as a result of warning notices, the number of beds available reduces. Land values are generally high across the county, which militates against easy development of new residential and nursing care facilities.

The full quota of vacant beds in East Sussex in June 2017, c.40% (180 out of 432) are with providers that do not accept placements from ESCC due to cost, or will only accept ESCC funding is substantial 'top ups' are paid by residents or their families. ESCC purchases in the region of 18,500 hours of



domiciliary care across the county per week. The requirement is split across 65 providers (2 Lead Providers and 63 Approved providers).

It became clear in early 2016 that significant issues existed within the domiciliary care marketplace in East Sussex, particularly with regards to capacity and responsiveness in the Eastbourne, Seaford / Havens and Lewes areas, which were having a significant impact on the wider health and social care system.

Further information can be found in the East Sussex Market position statement at <https://www.eastsussex.gov.uk/socialcare/providers/funding/market/>

Healthwatch East Sussex recently publicised a report bringing together the findings from a second wave of visits involving care homes providing nursing care.

<http://www.healthwatcheastsussex.co.uk/wp-content/uploads/2015/01/Overarching-Care-home-report-2017.pdf>

Key issues and challenges which the plan aims to address

The challenges facing East Sussex system(s) are recognised nationally however geographical and demographical factors heighten the level of risk which they present to our local plans.

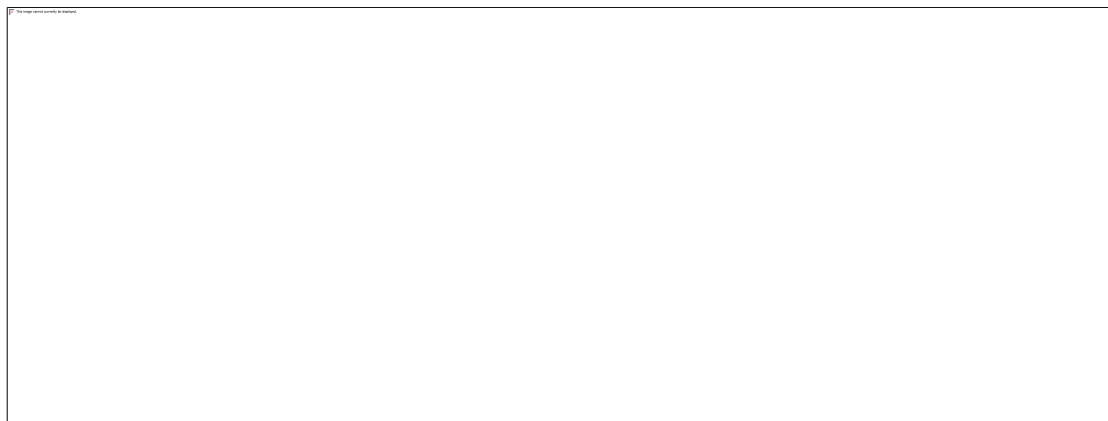
1. Finance
2. Workforce
3. Market

Further information about the risks and challenges facing East Sussex can be found in the Risk section on Page 31 and the section on Assessment of Risk and Risk Management on Page 41.

Progress to date

What have we achieved so far?

- ESBT have developed a single framework to bring together the entire spectrum of services people need to be fully supported at every stage of their health and care needs; this is called the 6+2 model.
- The first six boxes bring together our aspirations to focus on proactive care in order to meet people's needs, make sure services are joined-up and prioritise services that help people be more independent.
- The remaining two focus on 'prescribing' and 'elective care' (e.g. surgery and other planned care) where we believe we can make big improvements in value and service quality
- The framework makes sure we think about all of our populations, whatever their needs, in a way that focuses on the individual.
- This approach and methodology is firmly embedded in our local processes for Health Overview and Scrutiny, and Health and Wellbeing Board, including an ESBT specific scrutiny board within the Council, where members are all sighted on programme progress and developments as well as planned moves for new models of care.
- We have matured our partnership over three years and have robust relationships across our health and social care commissioners and providers that have ensured the foundations for success.



As we conclude our galvanising 150 week first phase of ESBT, we can demonstrate positive, mature relationships across our system-wide partnership that have enabled an integrated approach to achieving system-wide financial balance through our shared integrated 5 year Strategic Investment Plan (SIP) to deliver an increase in primary and community based services, reduce over-reliance on the acute element of our system, deliver in-year constitutional targets and integrate health and care (N.B. The SIP financial schedules are



publicly available on our ESBT website, and we will send them to you should you require sight of them).

We have made significant improvements in care pathways across health and social care. We have established:

- Health and Social Care Connect (countywide): an integrated adult health and care access and triage point that ensures that patients and clients, whether self-referred or referred by social care and clinical professionals, receive the right package of health and social care support quickly. In 2016/17 HSCC supported 119,488 people: c53,000 received information, advice and signposting; and c66,000 received community health and care services; a 14% increase on the previous year of establishment.
- In ESBT, the nurse-led Crisis Response Teams, which take referrals from general practice and help prevent unnecessary hospital admissions by arranging the right care, in the right place, at the right time for people whose long term conditions are deteriorating or who are suffering early signs of illness. This newly established service supported c.550 people in the community during its start-up year, with plans to increase this to over 1,500 in 2017/18.
- Our integrated health and care locality teams and communities of practice which bring together social and health community staff into integrated teams. The area is divided into eight such localities; three led by managers from social services and three led by managers from health. The locality teams are growing in strength and will be the focus through which we develop local alliances across the health, social, and voluntary sectors to identify service priorities and develop joint responses to them.
- ESBT saw a 4.3% reduction in our emergency admissions during 2016/17 compared with the previous year.

More information about improvements already made can be seen on the ESBT website <https://news.eastsussex.gov.uk/east-sussex-better-together/>, in addition to our key performance indicators demonstrating reductions in emergency hospital admissions and improvements in population health.

We have built on the widespread formal public consultations for significant service improvements and reconfigurations regarding maternity and paediatrics and orthopaedics, general surgery and stroke. Since 2013 we have ensured an ongoing programme of extensive public and stakeholder engagement that informs everything we do. This has included engagement to inform the establishment of ESBT, engagement in programme design, co-design of pathways and services; co-design of how we engage, citizen engagement in our governance, and improvements made based on people's experiences.

This engagement is the cornerstone of our approach and underpins our commitment to move beyond care pathway redesign as our original ESBT programme moves into business as usual, to focus on securing fully the triple aims of improved health and well-being,



improved experience, and financial sustainability through integrating commissioning and delivery of our health and social care system.

Connecting 4 You

What we have achieved so far:

- Dementia Golden Ticket; innovative and holistic enhanced support for those with dementia and their carers that has won National awards.
- Expansion of the Community Geriatrician service to all areas of HWLH
- Developed a comprehensive Frailty Strategy
- Commenced work to develop the Communities of Practice
- Significant reduction in excess beds days due to Community Pharmacy reviews/meds optimisation

In addition to the above, we have continued to make progress against the additional previous BCF national conditions:

Progress on our joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

East Sussex has been developing multi-disciplinary working, centred around risk stratification of GP Practice populations using Sussex Combined Predictive Mechanism (CPM). Monthly multi-disciplinary meetings have been taking place, working towards ensuring that all people who are high risk of hospital admissions have a care plan with a named lead professional.

As well as focussing on those at very high and high risk of hospital admission the Multidisciplinary team meetings also identify people at medium risk where their risk score is rising. Proactive care and interventions are then planned with the individual proactively to help prevent them deteriorating.

East Sussex Healthcare NHS Trust and Sussex Community NHS Foundation Trust have been working closely with East Sussex Adult Social Care to promote joint working within localities across the CCG areas. Joint working has also involved Sussex Partnership NHS Foundation Trust engagement and regular multi-disciplinary meetings, to ensure the holistic approach to person centred planning includes consideration of psychological wellbeing and mental health needs.

In 2016/17, Integrated Locality teams and Communities of Practice were implemented ensuring these joint working developments are built upon to define and implement locality models of care, ensuring accountable lead professionals are allocated and care plans are in



place for the identified patient/service user cohorts. Local Primary Care strategies envision GPs taking a lead in coordinating care for people at high risk of hospital admission.

Progress on the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

East Sussex has a good record of investing in community services that deliver “7 day working” in an integrated delivery model. This includes our integrated services such as Health and Social care Connect, the Joint Community Rehabilitation Team, Integrated Night Service as well as a range of other core services including District Nursing teams and homecare providers. Throughout 2017-19, Integrated Locality teams and Communities of practice will continue to develop and ensure a consistent, joined up approach to 24/7 community offer to support admission avoidance and discharge from hospital including at weekends.

In 2016/17, the crisis response service became fully operational 7 days a week across the ESBT area and in 2017/18 will be merged with the Integrated Night Service to provide a consistent 24/7 approach. There are plans to develop a similar service in the C4Y area in 2017/18.

The plans to further develop health and social care localities will provide a systematic approach to understanding any service gaps within local areas and inform future commission intentions.

Progress on data sharing between health and social care, based on the NHS number

It is the East Sussex intention that all health and social care services use the NHS Number subject to any outstanding resolution of national information governance issues. The NHS number is regularly matched to Social Care records held on Liquid Logic. The current coverage of the NHS number for active Social Services clients stands at over 90%.

We are committed to using systems that are based upon Open APIs and Open Standards. As providers implement new information systems eg. System One, we will look to maximise opportunities to improve the interface between systems to support integrated working.

“We commit ourselves to aim for interoperability (i.e. use Informatics systems that can communicate with each other through electronic means). When this is not possible in the short term, the CCGs will ensure the information they hold is capable of being viewed electronically by other parties, as appropriate. The CCGs are committed to system-wide solutions and system-wide behaviours to achieve this, and this commitment includes their work on Informatics. The principle of interoperability will apply to the CCGs’ commissioning and re-commissioning or procurement of new clinical services and Informatics systems. We



will ask our key providers to be mindful of these principles when they undertake their own procurement of new Informatics systems.” (Ref: Principle 9 of our Informatics Strategy)

We are committed to using systems that are based upon Open APIs and Open Standards, including use of GSX and nhs.net secure email. We also use the voltage secure email for communicating between East Sussex County Council and the public and third/voluntary sector.

“We are committed to being mindful and respectful of the need for best practice and take account of good IG practice, Caldicott, and the significant legal framework that supports this area of work. The CCGs’ default position will be for information to be shared, unless there are specific reasons why this should not happen (e.g. consent not given).” (Ref: Principle 8 of our Informatics Strategy)

The following key documents are explicitly referenced in the strategy:

- Securing excellence in Primary Care IMT.
- Caldicott Standards/Caldicott 2 Report.
- HM Government Information Sharing: Pocket Guide.
- Health and Social Care Information Centre Information Governance Toolkit.
- Information Commissioner’s Office (ICO) Statutory Data Sharing Cod of Practice.
- NHS Confidentiality Code of Practice.

We will review and continue to maintain an information governance framework that ensures we meet all Caldicott requirements. This will meet the NHS standard contract requirements and support professional and clinical practice. All practices’ compliance with the IG toolkit is monitored on a biannual basis.

Summary Care Records: Since the introduction of a local Vulnerable Patients Scheme in Primary Care in April 2016 we now have 10,493 Summary Care Plans with Additional information (SCR-AI) for our most vulnerable patients and this number is continuing to grow at a rate of 600-800 records a month. Prior to this scheme there were only 709 in place.

Community teams on SystmOne already have integrated access to SCR. Key information provided to GPs by community teams will be integrated within the shared SCR once recorded in the patient’s GP electronic patient record.

The SCR – AI will increasingly be used to share care planning information across a range of health settings.

Evidence base and local priorities to support plan for integration

The evidence base for our plans is set against the demographics, financial and other challenges in the social care market and health locally as detailed in the background and context section on Page 15.

Everything we do is based squarely on a consistent strategic framework which links directly to:

- Our detailed knowledge of the changing needs and demands for our services – encapsulated in our Joint Strategic Needs Assessment (JSNA);
- The shared priorities we have agreed through our Health and Wellbeing Board – encapsulating what we will do in all key population groups;
- The components of the new system we need to deliver and the enablers required to get us there; and
- The activity we need to undertake now through clear strategies for primary care, integrated service, mental health and a range of other strategic plans, which are practically based.

In East Sussex we are very clear on both the need and the opportunity to improve services through greater integration. The CCGs and East Sussex County Council are committed to commissioning a range of services to improve the health of people in East Sussex. Services must work together so people receive seamless health and social care that is designed around their individual needs. We will build on the existing skills and expertise in the community based teams and local people to deliver services that meet the specific health needs and geography for the people of East Sussex. This understanding has been determined through;

- Evidence from existing integrated and collaborative commissioning across health and social care in East Sussex
- Programme reviews to compare service outcomes and levels of investment – ie. spotlight those with relatively low outcomes yet relatively high spend
- The demographic trajectory of the population will require a greater focus on joined up care as more people live longer facing more co-morbidities and complex care needs.
- Understanding the opportunity to reduce the incidence of unplanned care in the form of attendances at A&E departments and emergency admissions to acute hospitals.



- Preventing or minimising people reaching a crisis that requires acute or unplanned interventions when it could be avoided, is the right thing to do.

A detailed analysis of the current position across East Sussex has been carried out, illustrating the current resource use and highlighting the challenges and opportunities. This includes a range of information pertaining to the following:

- Current activity and resource profile stratified by commissioner, by age, care type and provider;
- Predicted required health and social care resource vs available spend in a 'do nothing' scenario for each commissioner;
- Inequalities in health and unmet need;
- Opportunities for improvement based on best practice examples
- Benchmarking information supporting savings targets across secondary care and prescribing
- Initial savings targets and reinvestment levels
- Savings and reinvestment profiles and resulting surplus/deficit positions

Partnership planning in East Sussex

Over the last six months we have been reviewing the way people are involved in our strategic planning processes for health and care in East Sussex. We've been thinking about how we can improve these arrangements so that the experiences and expertise of stakeholders can be used better. This review has now been completed, and we've used what people have told us so far to put forward some recommendations for how we think it could work in the future.

By stakeholders we mean people or groups who have an interest in what an organisation does, and who are affected by its decisions and actions. Stakeholders include people who use services, their families and carers, voluntary and community sector organisations and independent providers.

What people have told us?

- Stakeholders value the opportunity to meet with senior officers from social care and health.
- The current system based around traditional adult social care groups of people isn't the most effective or efficient way of structuring our engagement any more.
- We could achieve greater value from a collective voice rather than the current fragmented structure.



- People want to broaden the focus of the current arrangements to consider the health and care across East Sussex as a whole.
- Stakeholders feel that partnership work is focused on the priorities of adult social care and health and partner organisations, and are keen to move towards a co-production approach.
- Existing groups and engagement activities need to be better linked into the strategic planning process.
- The new arrangements need to cover adults and children.

Based on what people have told us:

- There will be a new countywide, health and wellbeing stakeholder representative group that will work collaboratively to improve and shape health and care across East Sussex.
- This new countywide group will help to join up existing groups and other engagement activities.

We hope the new arrangements will help to:

- create a clear and transparent way for stakeholders to influence decision-making;
- give people an overview of health and care across the whole county;
- focus on outcomes rather than 'client groups' or labels;
- bring together discussions and planning around physical and mental health;
- create efficiencies for everyone involved;
- make best use of information gathered at a local and service level; and
- improve links between groups.

ESBT Locality planning:

Locality Planning Groups will support local strategic management in each of the identified localities. As a first focus and priority, the locality planning arrangements will enable performance management of patient flows, delivery of the appropriate and proportional locality contribution to the Strategic Investment Plan and provide oversight of proactive case management. Once this is established, and the learning from this taken on board, then they will become the place at which insight will be provided to improve understanding of local demand for health and social care services and to develop local support and service solutions. The Locality Planning Groups will coordinate and oversee an annual programme of work which builds a locality profile, identifies key local priorities, takes account of the resources available to the locality and supports the Integrated Locality Teams to achieve

activity targets and seek to resolve barriers to their achievement. The Locality Planning Groups will be accountable to the Alliance Executive through the Integrated Strategic Planning Group to provide assurance that locality plans will encompass all services including adults, mental health, learning disabilities and children

Connecting 4 You Engagement Plan

There is a programme of work agreed Sept 17-Dec 17 in regards to co-production of the development of the Communities of Practice (CoP) involving all key stakeholders in each locality with a priority focus on developing frailty and fall prevention services;

Engagement Plan for Implementation

Action	Date	Lead
Sign off engagement plan, focus, purpose and definitions CoPs at COP Delivery Group	6 th September 17	SCFT
Engagement with individual GP Practices ~ to share CoP Vision and Principles	September 17	CCG Cluster leads
Engagement with third and voluntary sector representatives ~ to share CoP Vision and Principles	September 17	Emily Smith/Sam Tearle
Engagement with JCR, ASC, SPFT ~ to share CoP Vision and Principles and discuss capacity to support	September 17	SCFT
C4Y CoP development Workshops to be set up in each of the 4 communities of practice. Aim of these is to discuss local context, discuss core work streams for each CoP and seek sign-up for local Steering Groups.	October 17	CCG Cluster Leads C4Y Team and SCFT to support with facilitation of the workshop.
CoP Steering Groups to start in each CoP area. These Groups will design and agreed their own priorities, deadlines and (high level) action plans for frailty and admission avoidance	November 17	CCG Cluster Leads



Better Care Fund plan

The East Sussex Better Care Fund Plans support the delivery of the ESBT and C4Y transformation programmes and plans which address the local needs identified and the vision for integrating health and social care.

Across ESBT and C4Y, the service redesign schemes and developments are significantly wider than those funded by the Better Care Fund as articulated in the vision outlined earlier in this narrative.

Brief description of schemes commissioned and priorities for BCF,

In line with ESBT and C4Y objectives, the BCF plans seek to support the key objectives of:

- Ensuring that every patient and client will enjoy proactive, joined-up care that supports them to live as independently as they can and achieve the best possible outcomes
- Keeping people as well as possible and helping us to act quickly when they become unwell or require help
- Ensuring people have access to the services when and where they need them
- Helping people stay in or close to home and minimise hospital admissions
- Ensuring our services are effective and affordable

To achieve these, the range of schemes listed in the planning template cover key areas of focus including:

1. Building community capacity to support admission avoidance activity and reducing length of hospital stays:

This includes:

- Community based Intermediate Care, both domiciliary re-ablement and bed based care and support.
- Crisis response and Integrated Night Service
- Falls and Fracture Programme
- CHC Assessment Staff

2. Developing alternatives to A&E:

This includes:

- Mobile App – Health Help Now
- Minor Injury Units
- Community Transport

3. Developing our approach to manage our frail older populations

- Frailty



- Proactive Care
 - Carers Services
 - Telecare/Telehealth
4. Developing our approach to supporting self-care and self-management
- Health and Social Care Connect
 - Proactive Care
 - Know Your Own Health
 - Diabetes
 - DFG developments
 - Expert Benefits Advice
 - Stroke Support and Living Well
5. Medicines Optimisation
- Medicines Optimisation in Care Homes
 - Medicines Optimisation – waste disposal
 - Community Pharmacies

These schemes will support the delivery of all of the national BCF metrics, many of these schemes are jointly commissioned and jointly provided by Adult Social Care and local NHS Trusts. The schemes support the development of integrated locality teams and the move towards planning and designing services around local communities as a cornerstone of both ESBT and C4Y visions for integrating care and support.

In addition, focus has been given to developing preventative services which adopt a proactive approach to supporting people at earlier stages of care pathways.

Improved Better Care Fund (iBCF)

There is an agreed approach to the use of IBCF money across ESBT to increase capacity and stability in the care market and the approach for the C4Y area will be agreed through that programme governance.

The iBCF is included in the East Sussex BCF plan as detailed in the planning template and will be included in the s75 agreements.

Local NHS Trusts are fully involved in planning schemes to manage discharge in line with the implementation of the High Impact Change Model as detailed in the attachments on Page 49.

In line with the grant conditions, the iBCF money in East Sussex will be used to support:



- Market sustainability: Following fee increase negotiations, care providers are recruiting staff with a view to increasing available capacity.
- Meeting Adult Social Care Needs: Protection of current level of social care services to ensure supply meets current demand.
- Hospital Discharge to Social Care: Provision of timely and appropriate funding to place people into Social Care once they are ready for discharge from hospital, and so improve the level of DToC performance across the East Sussex system

Agreed use of DFG monies

The Districts & Boroughs of East Sussex have each created revised discretionary policies to allow for flexible use of DFG funding. This has resulted in a number of projects going forward such as acquisition and development of adapted properties, improving access to accommodation to facilitate hospital discharge and County wide roles to coordinate the new initiatives.

The funding is acting as a catalyst for partners across East Sussex to come forward with projects which achieve strategic priorities across housing, health and social care. Examples would be the renewed focus on bringing forward initiatives to support with delayed transfers of care and creating new initiatives in terms of acquisition of new homes and new build development to meet complex housing need.

The partnership across East Sussex is continuing to grow under the two transformation programmes of ESBT and C4Y. Districts & Boroughs are represented at these Boards and share a joint agenda – to provide the best quality of services for the people of East Sussex.

There are operational and strategic groups to specifically focus on adaptations and support solutions across East Sussex set up which includes the voluntary sector. We are currently aligning our planning and design processes under ESBT and CFY to ensure that representation from housing authorities and the VCS is integral to our future ways of working.

Work is underway to explore supply and demand of accommodation options for the most vulnerable across East Sussex with a focus on older persons housing and care in particular driven by demographic changes. This will conclude with a strategy which outlines our future commissioning prospectus and market communication and engagement.

Risk

Key issues and challenges which the plan aims to address

The challenges facing East Sussex system(s) are recognised nationally however geographical and demographical factors heighten the level of risk which they present to our local plans.

1. Finance
2. Workforce
3. Market

1. Financial context

In order to make the required changes, it is important to understand all aspects of the financial context as illustrated below:



The ESBT Strategic Investment Plan sets out the vision and approach to fully integrate the health and social care economy across the ESBT footprint in order to deliver safe, high quality, affordable and sustainable services to the local population.

Format and content of the SIP includes:

- Narrative – articulates how we will collectively invest our c. £1bn to meet local need and shift the balance of service provision from reactive hospital based care to proactive primary and community care.
- 5 year plan – tracks estimated impact of interventions on demand on the system in activity and financial terms



- 17/18 Plan & trajectories by point of delivery

The ESBT Strategic Investment Plan (SIP) models the shift in health and social care spending from a commissioner perspective required to bring the system into financial balance. It does this by tracking the impacts of all of the transformational projects being implemented as part of East Sussex Better Together (ESBT). The SIP currently shows there are plans at various stages of development which cover the initial £39.9m delivery challenge in 2017/18. Although the SIP describes the system-wide financial impacts of ESBT projects, it should be noted that quality metrics are integral to each scheme and are regularly monitored at that level.

HWLH CCG has a target surplus for 2017/18 of £0.8m. It is currently reporting to NHS England that it will meet this target. However, it recognises a significant net risk of £8.4m. The achievement of the required surplus will only be delivered through the achievement of QIPP targets which relate to the transfer of activity from the acute to community health and social care setting.

The pressures upon the CCG's outturn are mainly showing within acute services where significant over-performance has emerged during the first quarter of the year. The CCG is currently showing a quarter 1 overspend of just over £2m at the main acute provider Trusts. This is currently being mitigated from the contingency and QIPP savings delivered (primarily on medicines optimisation).

The overspends on the acute side are largely due to elective and non-elective admissions. There is also significant over-activity materialising in A&E attendances although the financial impact is less.

BCF Contingency Fund

HWLH CCG holds a BCF contingency fund of £2.9m. The CCG is implementing programmes aimed at reducing non-electives admissions. The CCG is holding some of its BCF funding in contingency to mitigate against additional financial risks of under-delivery of QIPP targets aimed at reducing non-elective admissions. The contingency is being released monthly through the course of the financial year.

2. Workforce context

The Sussex and East Surrey Sustainability and Transformation plan has developed a workforce strategy to deliver the transformation required to serve the needs of our population.



The challenge for the workforce programme is to address the immediate problems and support the plans for winter pressures, whilst developing the strategic solutions for a sustainable future. The STP has set up a Local Workforce Action Board to lead and implement the workforce strategy to support the STP. Board membership includes representation from the new clinical leadership, commissioning, social care and the independent sector. Health Education England is providing programme management, and resource to ensure that the actions, particularly the priorities, will be implemented.

East Sussex Better Together Workforce Strategy 2016/2018

The realisation of the ESBT programme requires a workforce that has the capacity and is equipped to deliver the new models of care at a time of unprecedented workforce supply issues across many key roles in both health and social care sectors. Workforce leads from stakeholder organisations have therefore, come together to develop a workforce strategy that will deliver the workforce transformation that is required in terms of role design, training, workforce planning and the deployment of the health and social care workforce.

The strategy recognises that such a wide reaching transformation programme needs to be supported by a change management approach that is more fluid, innovative and prepared to take manageable risks. For this reason the strategy is designed to be flexible and able to respond to the evolving priorities of the ESBT programme whilst also being aligned with the draft workforce priorities set out in the Sussex and East Surrey STP at the time of publication. The strategy's vision for the workforce is articulated in the form of nine aims which are to be achieved through prioritised objectives for each year of the strategy. A key enabler to creating a workforce that is able to work differently in delivering integrated healthcare services is Organisational Development (OD) at provider level in order to achieve system transformation. In this respect, the strategy also describes examples of the key OD interventions to be applied in achieving this goal.

For further information regarding Risk Management - please refer to the Section titled Assessment of Risk and Risk Management on Page 41.



National Conditions

National condition 1: jointly agreed plan

The East Sussex Better Care Fund Plans support the East Sussex Better Together and Connecting for You Programmes which are agreed by the East Sussex Health and Wellbeing Board and jointly agreed between the commissioning and provider organisations within the East Sussex HWB footprint.

All parties to the ESBT and C4Y programmes have agreed to the approaches and other affected organisations have been involved in the transformation plans. This includes agreement to the use of the iBCF money to stabilise the care market and contribute to reducing delays in transfers of care

The DFG funding been passed down by the county to the districts in full and work is underway to jointly develop the plans on how this funding will support a strategic approach to health, care and housing.

National Conditions (continued)

National condition 2: social care maintenance

We aim to ensure the protection of social care services in East Sussex by ensuring that the legal responsibilities and duties required in Law and regulation are represented in any future operating models, namely:

- Adult social care means the care and support provided by local social services authorities pursuant to their responsibilities towards adults who need extra support.
- The Local Authorities responsibilities towards adults who need extra support are set out in the Care Act and a list of statutes in the NHS and Community Care Act 1990, where they are referred to as assessment for and arrangement of community care services.
- Community care services are those which local social service authorities are required to provide if assessed as needed.
- Relevant social work in adult social care is that which is required to be provided by local social services authorities if assessed as needed.
- Registered social workers are trained to undertake relevant social work and are registered as capable of so doing.

Year on year we continue to support people to remain living independently in their own homes, with maximum choice and control over the support they receive. Within the context of growing demand and significant budgetary pressures we want to continue to develop personalised services by approaching them in a more innovative way. We want to help more people to help themselves, as well as focusing on reablement and more proactive support to ensure people remain well, are engaged with self-management, and where ever possible improve people's independence so they can stay within their own home and avoid admission to hospital and/or institutional care

The ambition is to ensure that all partner organisations recognise the value of social work and social services and the key role they play in the management of services that are focussed on prevention, cost avoidance and maintaining independence

NHS funding for social care has been used in East Sussex to enable the local authority to sustain the current level of eligibility criteria. It is also being used to continue to provide capacity within the range of social care services outlined below:

The planned spend on Social Care from the BCF CCG minimum allocation includes an increase in line with inflation for 17/18 and 18/19 from the 16/17 baseline

Health funding for Social Care 2017/18 :

As in our previous BCF plans, the contribution to social care is to be spent on social care services that have some health benefit and support the overall aims of the plan as outlined below.

The details in this table link to East Sussex BCF Planning template - Tab 3 HWB Expenditure - Scheme ID 1 and Scheme ID 2.

Health funding for Social Care Categories	Commentary - service and activity	Area Team Subjective Codes	17/18 Planned £'000	18/19 Planned £'000
Telecare	Telecare/Telehealth	52131016	301	301
Integrated Crisis and Response	Integrated Night Service	52131017	62	62
Re-enablement Services	Including JCR and ICAP/HSCC	52131019	1,165	1,165
Bed Based Intermediate Care	Including Milton Grange and Firwood	52131020	451	451
Early Supported Hospital Discharge Schemes	Including hospital teams	52131021	636	636
Mental Health Services	Including Assessment and Care Management	52131022	1,604	1,604
Other Preventative Services	Including stroke support and Living Well	52131023	134	134
Community Equipment and Adaptations		n/a	-	-
Maintaining Eligibility Criteria	Eligibility maintained at Substantial and Critical	52131018	5,343	5,605
Total Investment of Health funding for Social Care			9,696	9,958



National Conditions (continued)

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

Planned BCF funded out of hospital services have been identified for 2017-19 amounting to:

2017/18 - £13,368,232

2018/19 - £13,534,867

The Section 75 agreements will ensure governance arrangements are in place to agree release of the ring fenced funding in line with agreed expenditure profiles. Any under or overspend against this allocation will be dealt with under the agreed risk share principles which will form part of the section 75 agreements.



National Conditions (continued)

National Condition 4: Managing Transfers of Care

All aspects of the High Impact Change framework for Managing Transfers of Care are being implemented across East Sussex.

Further details of this can be found in the section Delayed Transfers of Care on Page 47.



Overview of funding contributions

*N.B. Please refer to the **East Sussex HWB Planning template** for further details of funding contributions.*

The funding contributions for the following components of the Better Care Fund pool have been identified to be used for that purpose and as agreed with the relevant stakeholders and in line with the National Conditions and as set out in the East Sussex HWB Planning template:

- Maintaining Social Care
- Implementation of Care Act duties
- Funding for Re-ablement
- Funding dedicated to carer-specific support
- Disabled Facilities Grant
- iBCF



Programme Governance

As partners we are working collectively for the whole system to create, agree and implement a clear and credible plan for a sustainable system of health and social care to secure the best possible outcomes for East Sussex residents, over and above immediate organisation interests.

In ESBT, we have put in place an Alliance Agreement, together with an integrated 5 year whole system strategic investment plan which describes the Year of Care costs over the five years, and the shifts between care settings that we need to see. An integrated governance structure has been put into place to support commissioning and delivery, and this includes strategic commissioning and oversight, and clinical end executive leadership of the whole system. This now gives us increased flexibility in the way we use our resources as a system, to test new ways of working and improve services for our local population in 2017/18 and in the longer term. This paves the way for a future model that integrates our whole system, and by July 2017 we will also have completed the work to agree the legal vehicle for our future model.

Good governance between East Sussex organisations provides the direction and leadership for the system, assurance that Transformation programmes, further enabled by the Better Care Fund, are working together to deliver the overall strategic objectives and that risks have been identified and managed.

Our governance structures are centred around East Sussex Better Together & Connecting 4 You ensuring clearly defined relationships to the respective organisations' governance structures, the Health and Wellbeing Boards and the governance supporting the Sustainable Transformation Plan.

The governance structures are ensuring each of the following four aspects are clearly articulated, responsibilities assigned, and relationships agreed;

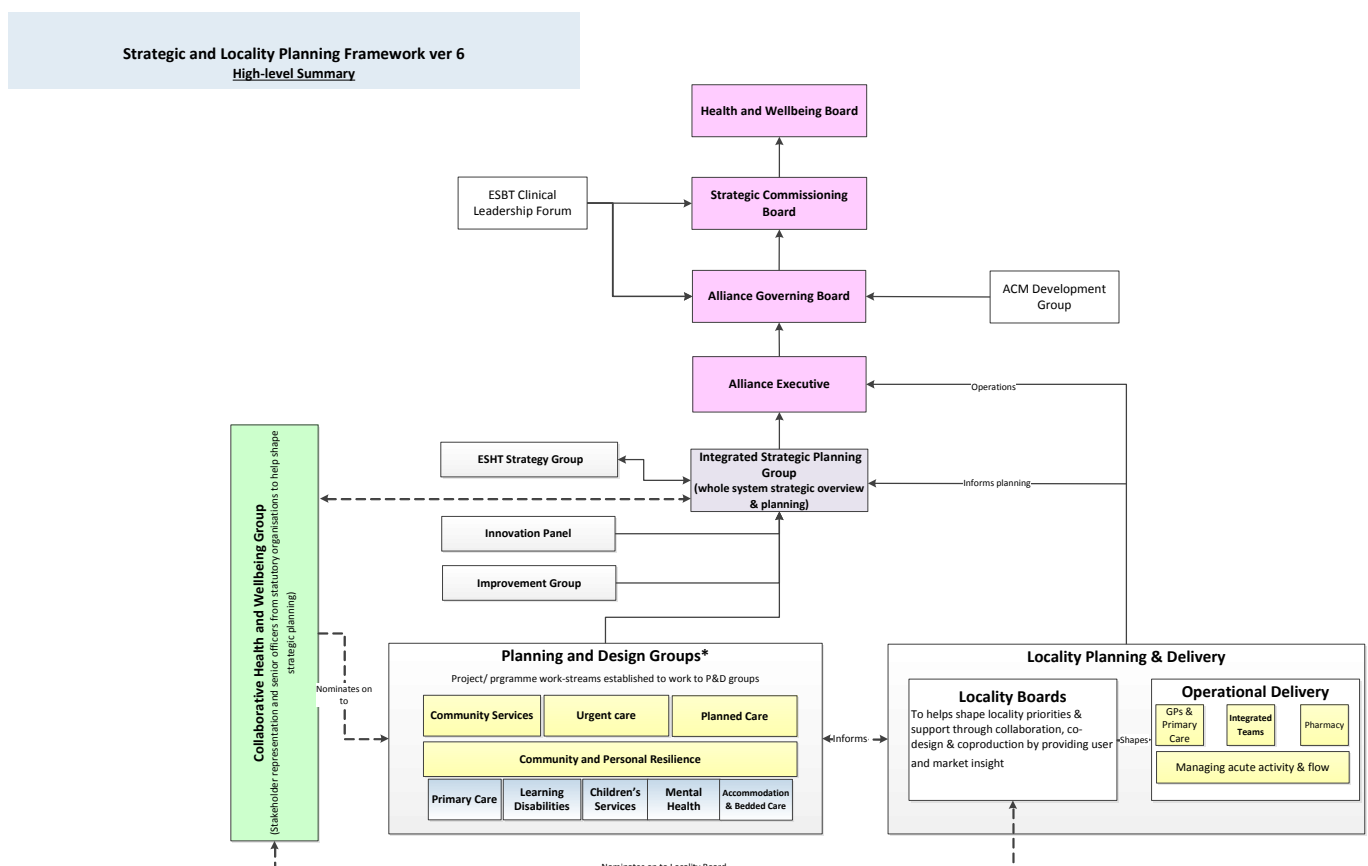
- (1) Thought leadership – system, clinical and community
- (2) Decision-making
- (3) Delivery
- (4) Assurance

The over-sight and management of the Better Care Fund in East Sussex will be via the existing governance arrangements for the ESBT and C4Y programmes – as detailed below

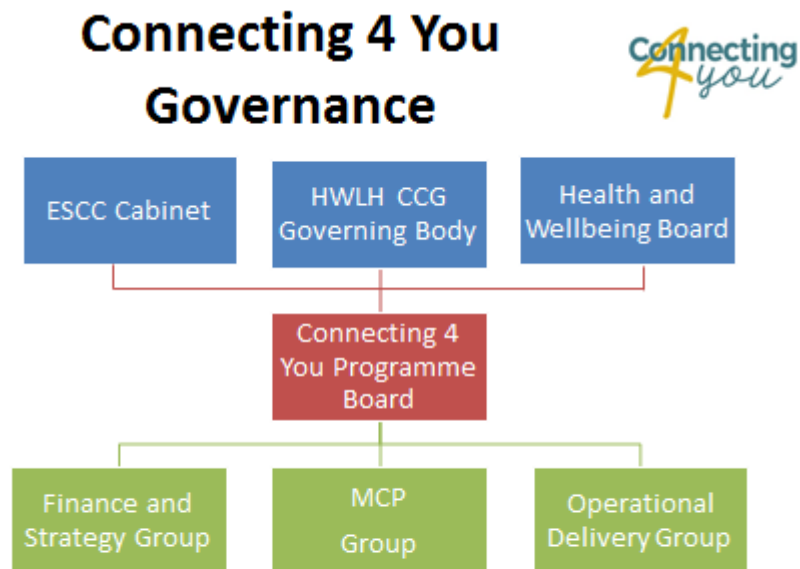
Both programmes are supported by a Programme Management Office which ensures a clear jointly agreed approach to manage the delivery of the programmes including:

- Benefit realisation
- Capturing and sharing learning regionally and nationally
- An approach to identifying and addressing underperforming schemes and ensuring timely preventative action is taken when needed

ESBT programme governance structure



C4Y programme governance structure:



Operational Delivery Group:

The purpose of this Group is to oversee, coordinate and support the design and operationalising of the four Communities of Practice

Finance and Strategy Group:

The agreed objectives of the group are to oversee:

- Control on Current Investment
- Develop a detailed spending profile of each of the four Communities of Practice
- Development of the Strategic Investment Plan for HWLH

MCP Group:

Forum to oversee the shape and development of a Multi-specialty Community Provider model for HWLH

Assessment of Risk and Risk Management

The challenges facing East Sussex system(s) are recognised nationally however geographical and demographical factors heighten the level of risk which they present to our local plans.

1. Finance
2. Workforce
3. Market

ESBT and C4Y programmes are supported by separate Programme Management Offices who oversee the main risks to plans and ensure an agreed approach to managing these risks.

Within the C4Y programme, the process of review and scrutiny of risks is detailed in the HWLH CCG Risk Management Policy. These risks along with the scoring of severity and actions being taken to mitigate these are recorded using a corporate risk management software package Datatrix. All risks are updated on a bi-monthly cycle as a minimum. Important changes can and should be updated at any point. The last full review of and update of all the CCG's risks was undertaken by the Management Team during June 2017. ESCC uses a similar system.

At the September meeting of the C4Y Strategic Investment and Planning Group there will be a focus on determining whether there needs to be a combined C4Y risk management system developed or whether the two existing systems can be used in parallel.

Financial Risk Management:

Within the Section 75 agreements, partners will agree risk share principles which provide for financial risks arising within the commissioning of services from the Better Care Fund pooled budget, as set out below and in line with arrangements for previous years of the Better Care Fund,

RISK SHARE PRINCIPLES IN RESPECT OF THE EAST SUSSEX BETTER CARE FUND

The agreement will describe the key principles underpinning the risk share arrangements between Commissioners in East Sussex in respect of the Better Care Fund (BCF). These commissioners comprise High Weald Lewes Havens (HWLH) CCG, CCG Eastbourne, Hailsham and Seaford (EHS) CCG, Hastings and Rother (HR) CCG and East Sussex County Council (ESCC). These principles should be applied consistently to each East Sussex Health and Wellbeing Board Framework Section 75 agreement relating to the Better Care Fund and the Commissioning of Health and Social Care Services within East Sussex.



The governance of the risk share principles on behalf of HWLH and ESCC will be the Connecting 4 You Programme Board. The governance of the risk share principles on behalf of EHS CCG, HR CCG and ESCC will be the East Sussex Better Together Alliance Executive Board.

The BCF is intended to provide a framework for investment in schemes that promote better integration between social and health care services, to improve people's health and social care experience while also delivering the benefits identified in the Connecting 4 You and ESBT programmes.

Individual organisations are jointly responsible for risk managing the BCF s75 pooled budget arrangements and shall reflect and report identified organisational risk in their own corporate risk registers.

Where there is any inconsistency between the risk share principles set out in this schedule and a s75 agreement, the relevant Programme Board will determine the appropriate action.

Principle 1

The risk share fund and contingency arrangement are intended to address financial risks associated with the delivery of the 2016/17 BCF plan and ensures BCF investment does not cause a CCG partner to over extend in financial terms and put the achievement of its financial balance at risk.

Principle 2

That a risk share fund is established for each CCG which as a minimum is equal to the difference between the value of planned BCF healthcare activity reductions and the reductions realised within 2016/17 healthcare contracts. The full value of the risk share fund is retained by each CCG from their BCF allocation which is paid into the pooled budget at the beginning of the year.

Principle 3

A contingency fund is established at the beginning of each year within the Pooled Fund equal to the difference between total BCF investment (excluding Risk Share Funds) and forecast expenditure in total on the individual approved BCF schemes.

Principle 4

New business cases for BCF will be approved by the relevant Programme Board or delegated sub- committee. Investment shall include a clear appraisal of financial risks associated with delivery and provide clarity on whether financial risk crystalizing is an appropriate call on risk share fund or contingency arrangements. The relevant Programme Board shall agree all investment decisions and risk handling mechanisms.

Principle 5



The lead commissioner as identified within the s75 agreements will be responsible for reporting to the Programme Boards the achievement of the BCF plans and for ensuring commissioning contracts reflect BCF savings and investment plans.

Principle 6

Each organisation will annually and following a properly conducted risk assessment of each BCF saving and investment scheme provide the relevant Programme Board with a detailed plan of how the total quantum of risk is mitigated. The assessment shall include the likelihood and impact of each scheme delivering the expected outcomes at an organisational level in terms of activity reduction, cost reduction and operational and quality indicators.

Principle 7

The East Sussex Finance Sub Group will be responsible for co-ordinating the performance management of BCF schemes and will report to the relevant Programme Board quarterly. The East Sussex Finance Sub Group will make recommendations to the relevant Programme Board regarding mitigating actions, the application of risk share funds, contingency and underspends on schemes and the source of any additional pool funding required.

Market Risk Management:

The ESCC Quality Monitoring Team is in the process of a restructure. From November 2017, the team will be known as the 'Market Support Team' with a clear focus on supporting providers to improve the quality of their service in order to improve outcomes for adults receiving care and support in East Sussex.

The ESCC Quality Monitoring Team (QMT) work closely with CQC Social Care Inspectors to identify services who may present as high risk of not providing consistent good quality care, which could potentially impact on the wellbeing and safety of adults with care and support needs. The Quality Monitoring Team will work with care providers to offer bespoke support and/or signposting to other services/best practice guidance. Joint work between ASC Quality Monitoring Team and the CCG Quality Nursing Team is regularly undertaken to ensure that providers are supported with clinical, care and business issues as appropriate.

The Quality Monitoring Team co-ordinate and lead on the Business Continuity process where it has been identified that the ongoing viability of a service is at risk.

The team maintain links with neighbouring areas to ensure key information and market intelligence is appropriately shared between areas



Workforce Risk Management:

Strategic workforce planning is considered to be crucial to the delivery of workforce strategy. The strategy addresses workforce supply issues through a range of recruitment and retention initiatives as well as considering the benefits to be gained through the design of new, blended or extended roles. The strategy also recognises the need to address the current capacity crisis within Primary Care and sets out the mechanisms to be put in place to support delivery of the workforce priorities within the GP Five Year Forward View and the previously published CCG Primary Care Workforce and Sustainability plan. This includes creating a Community Education Provider Network (CEPN) for the ESBT footprint.

The ESBT Community Education Provider network (CEPN) has ESBT system wide representation, including GP Tutors, GP training course directors and Practice Workforce Tutor. The current focus of the CEPN is the development of primary care staff in order to improve access to a GP and other health professionals whilst attracting and retaining all levels of staff in primary care. CEPN membership ensures that education and training decisions to support primary care workforce planning are taken with a system wide view rather than just from a primary care perspective.

The strategy has been co-designed and signed up to by the senior workforce leads within each provider stakeholder organisation. The strategy therefore, includes a set of working principles to facilitate jointly agreed solutions to ESBT workforce agenda issues and applies equally to ESBT partner organisations.

National Metrics

The metrics set for each of the 4 national metrics are aligned with existing targets for these areas as agreed across East Sussex Better Together and Connecting 4 You programmes

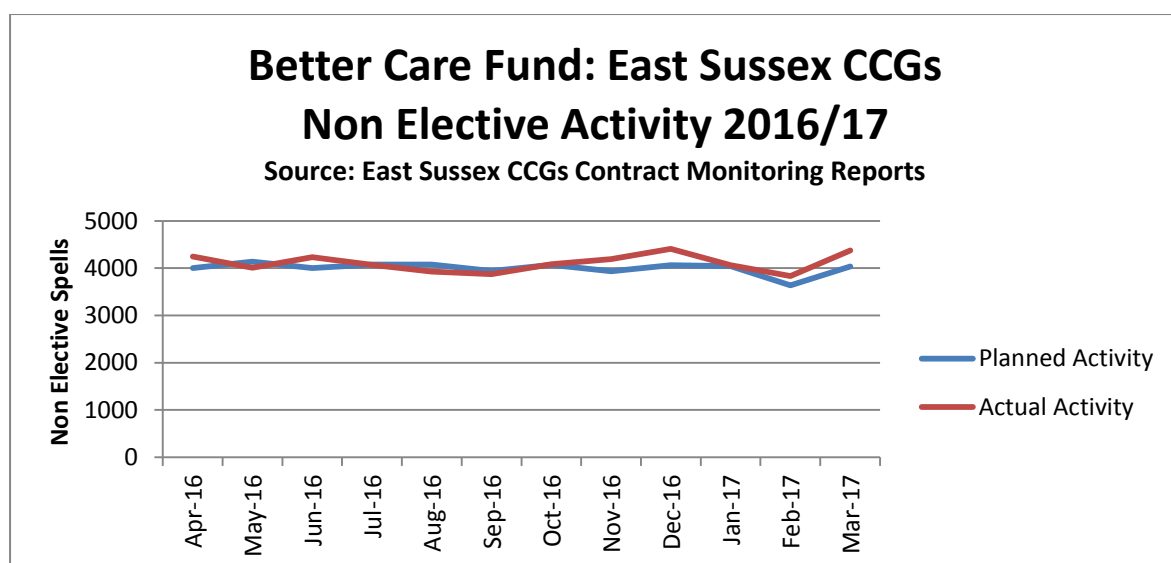
Non-Elective Admissions

The NEA metric is aligned with CCG operating Plans for 2017-19. No further reductions in Non-Elective Admissions additional to those in the CCG operating plan have been considered at the current time.

These NEL reductions have been derived 'bottom up' for each transformational scheme through:

- identifying current NEL activity associated with the patient cohorts that will be impacted by the scheme
- determining capacity and efficacy of each scheme
- calculating the resultant/anticipated reduction in NEL/Admission avoidance

Robust and relevant/appropriate monitoring processes are being implemented for each scheme both to confirm 'clinical effectiveness' and ensure progress against NEL target is understood – with remedial action taken where necessary. This includes reviews of the previous year's performance (please see below) and regular consideration of 'risk factors' eg recruitment that may impact on a schemes ability to deliver. In addition, targets for reduction have been clearly identified in acute contracts with local NHS providers on a scheme by scheme basis.





HWLH CCG holds a BCF contingency fund of £2.9m. The CCG is implementing programmes aimed at reducing non-elective admissions. The CCG is holding some of its BCF funding in contingency to mitigate against additional financial risks of under-delivery of QIPP targets aimed at reducing non-elective admissions. The contingency is being released monthly through the course of the financial year.

Residential Admissions

The East Sussex target for 2017/18 is 705 and for 2018/19 is 700.

Performance for 2016/17 was 531.6 (equating to 721 permanent admissions). As East Sussex is performing well in this area, we seek to only make small reductions during the next 2 years. Therefore the plan for 2017/18 is to reduce number of admissions to 705. 2018/19 targets are provisional at this time and will be reviewed as part of our annual target setting process.

The ESBT and C4Y programmes place significant focus on supporting people to remain in their own homes and live as independently as possible. Through the development of community services it is expected for the number of permanent admissions to residential and nursing care homes to reduce in line with the identified target.

Re-ablement

The East Sussex target for 2017/18 is 90.2% and maintaining this position for 2018/19.

Performance for 2016/17 was 90.5% (equating to 267 out of 295). Current performance is good and therefore the plan is to maintain performance above 90%

The ESBT and C4Y programmes place significant focus on supporting people to remain in their own homes and live as independently as possible, additional investment has been made in intermediate care and re-ablement services over recent years to ensure a high quality, consistent approach to achieving this.

Delayed Transfers of Care

The quarterly targets submitted in the BCF Planning template are in line with the expected reductions in DToC for social care and NHS attributed reductions for the HWB area as set out in the DTOC Metric Plan for 2017/18.



2018/19 targets are provisional at this time and will be reviewed as part of our annual target setting process.

Within the DTOC Metric Plan, no changes were made in the attribution of NHS, social care and jointly attributable delays.

Full details of the plans to support these targets can be found in the section ***Delayed Transfers of care*** on Page 47

Delayed transfers of care

Key reference documents:

- East Sussex System Improvement Plan



East Sussex System
Improvement Plan for

- East Sussex Surge Management and Capacity Plan 2017/18



Draft East Sussex
Surge and Capacity P

The **High Impact Change framework for Managing Transfers of Care** has been used to outline current services in place and planned developments to support timely Transfers of Care across East Sussex. Further detail can be found here:



High Impact Change
Model Self-Assessment



Copy of 17 05 08



Draft Winter plan

High Impact Change 12017-18 v.1 2007201

Early Discharge Planning:

Over the past few months, ESHT has implemented roll-out of the Red2Green process (SAFER patient flow bundle) across all adult inpatient and community wards, excluding maternity. The initiative commenced in February 2017 and has now entered a phase of embedding. Wards have nominated clinical champions to ensure increased and continued awareness of the methodology and processes involved with Heads of Nursing providing a Buddy role. Weekly audits are undertaken to ensure wards are aware of how they are doing and awareness sessions are continuing to offered to all staff with good take up including clinicians, nursing, therapies, ASC and non-clinical staff. Work is about to commence in the development of Criteria-led discharge pathways.

This is supported by the implementation of a stranded patient review process for patients with a length of stay of 7 days and over and a monthly consultant lead Complex Panel review takes place to help with very complex cases. A weekly length of stay report is also produced. Standard Operating Procedures are in place for the Red2Green weekly audit and report, Stranded Patient weekly reviews and necessary actions are discussed at a daily meeting between Hospital Directors and the newly formed multi agency Integrated Discharge Team.



A dedicated hospital team of social care staff take referrals from BSUH, follow up queries and take part in daily telephone conferences in order to facilitate prompt discharge. This team acts as a central point for all BSUH referrals to ASC that are not suitable for Joint Community Rehab JCR.

Work is underway with SCFT to explore how community services can provide increased in-reach into the hospital to support discharge.

Systems to Monitor Patient flow:

System capacity and demand information will be automatically populated onto SHREWD (Single Health Resilience and Early Warning Database) from each critical stakeholder across the urgent and emergency care system and refreshed, as a minimum, daily and more frequently dependent on how fluctuations in capacity and demand are managed within the specific service

Across the ESHT system, an Operational Executive (OpEx) has been established to oversee the day to day operational management at an executive level of the health and social care system and to identify and resolve any immediate and underlying system, process and capacity issues that negatively impact on the timely flow of patients through all elements of the health and social care system.

Within the BSUH system, HWLH CCG and ESCC Adult Social Care are represented on daily telephone conference calls.

Multi-Disciplinary Multi-Agency Discharge Teams

Across ESBT, an Integrated Discharge team has been established to provide a fully Multi-Disciplinary Multi-Agency Discharge Teams approach to co-ordinating transfers from hospital

Within C4Y, SCFT, ESCC and other partners are to developing an integrated approach to the provision of health and social care for all residents on the HWLH area.

Within the BSUH hospitals, ASC works closely with discharge co-ordinators to ensure co-ordinated approach to discharge.

Discharge to Assess:

Development of a Discharge to Access model (Home First) is currently underway with the model expected to be implemented by quarter 4 of 2017/18 to minimise lengths of stay for patients, maximise independence and to improve outcomes for patients and their carers.



This will allow patients who could receive therapy input in their own home environment to be discharged earlier in the pathway. A pilot is to commence from August 2017. An audit undertaken in ED over a 24 hour period identified that at least 10 patients during the period could have had their admission avoided by this model.

- Increasing capacity in the independent care market.
 - Above inflationary fee uplifts for Independent care providers, specifically Home Care and Nursing Home.
 - Review threshold for temporary residential care for people awaiting complex care packages from acute and community settings.
 - Explore additional funding required to increase existing nursing home capacity.
- Extension of the role of JCR beyond its current re-ablement service model to provide homecare to any patient who is assessed as needing homecare but for whom independent sector is not available. Recruitment to additional has faced challenges but is ongoing.
- Working with housing providers to explore potential for using extra care housing voids as transitional arrangements for patients with housing issues or awaiting housing adaptations

Seven-Day Service

Many community services operate 7 days per week across East Sussex. These include Community Nursing and Joint Community Rehab (JCR) which provide much of the domiciliary support following hospital discharge. In addition, there is an Integrated Night Service which provides nursing and social care cover between 10pm and 8am to ensure 24 hour support is available when required.

Independent care providers are offered financial incentives to assess potential clients and weekends and thus progress timely discharge

Further work is underway to focus on increasing hospital discharges at weekends.

Trusted Assessors

- Trusted Professional: Continue to Identify where 'trusted assessor' arrangements could remove any delays. Implementation of trusted social care + equipment assessor training for NHS staff as appropriate.
- Trusted Assessors for Care Homes: A Trusted assessor role which will be led by ASC in collaboration with Nursing and Rest home managers to agree the appointment of an individual who can undertake Care Home assessments with assessment on the day of referral to ensure the best outcomes for patients in a timely manner. Engagement with



Care homes to progress the Trusted Assessor model has begun; initial interest was low but further consideration is being given to how to attract Care Homes to the scheme in partnership with the East Sussex Residential Care Home Association.

Focus on Choice

The choice policy has been adapted, agreed and implemented to meet local requirements. There is work underway to explore what additional support could be given to families when looking for placements, arranging care and preparing for patient's discharge. Increase use of temporary placements for patients whilst exercising choice.

Enhancing Health in Care Homes

Care Home Plus: Negotiations are underway with care home providers to enable them to take clients/patients who traditionally are admitted to nursing homes but whose needs do not require registered nurse oversight. The intention is to purchase these enhanced beds in blocks of between 5 and 10. However this will require the support of primary care and district nursing services.

Equipment Provision; equipment is routinely provided to people living in care and nursing homes to ensure their individual needs are met in the same way those living in the community.

Frailty Practitioner Service - provide support to frail patients within care homes including:

- **Advanced Care Planning and Peace Plans** - allowing the individual to make choices and to have control in the management of their future care and illness. Creating an advisory plan which is shared with other healthcare professionals.
- **Review by Consultant Geriatrician** - weekly 'virtual ward rounds' allow particularly challenging cases to be discussed where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptoms.

Local action plan to reduce DTOC and improve patient flow:

The East Sussex System Improvement Plan incorporates 6 key areas for improvement to achieve sustainable urgent care across East Sussex. The key areas are:

- A&E Streaming;
- 111 Call Handling;
- Ambulance response programme;
- Patient flow;
- Improved discharge; and
- Ambulance handover.



The plan is updated monthly to provide the oversight and assurance of progress and to highlight areas for escalation. Monthly additions appear in red in the plan.

ESHT are currently undertaking a review of the Trust's Urgent and Emergency Care Improvement Project which will link to a full review of how the System Improvement Plan is presented and utilised for future LAEDBs. This is scheduled to be completed at the end of September and outcomes and benefits will be detailed in the next phase of the project.

The BCF will support the ESBT and C4Y programmes in delivering the service improvements required to deliver against the system recover plan.



Approval and sign off

The Better Care Fund plans support the ESBT and C4Y transformation programmes which have been agreed by partners as outlined in this paper.

In addition, the final BCF plans have been agreed by the following:

Name	Title
Amanda Philpott	Chief Officer, EHS & H&R CCGs
Wendy Carberry	Chief Officer, HWLH CCG
Keith Hinkley	Director of Adult Social Care & Health, ESCC
Becky Shaw	Chief Executive, ESCC
Cllr. Keith Glazier	Chair, East Sussex Health and Wellbeing Board

The Chair of the East Sussex Health and Wellbeing Board has approved the plans on behalf of the Board.

The date of the next East Sussex Health and Wellbeing Board is Tuesday 19th December.