HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	**Home First Programme (including update on the Better Care Fund)**
Meeting date	18 January 2021
Status	Public Report
Executive summary	Due to the Covid 19 Pandemic NHS England and Improvement advised Health and Wellbeing Boards (HWB) that Better Care Fund (BCF) Plans would not be submitted for approval for the 20/21 year or submit local targets, including Delayed Transfers of Care. HWB areas must, however, ensure that use of the mandatory funding contributions for the BCF have been agreed in writing, and that the national conditions are met. From 19th March 2020, integrated care systems including Dorset put into place the national Hospital Discharge Service Policy to enable hospitals and services to meet an expected first surge of COVID-19. Additional funding has been made available to support this, providing fully funded care for people discharged from hospital with care and support needs from 19 March 2020 to 31 August 2020. The Council continue to fund some elements of these costs related to hospital discharge including some from BCF budgets. From the 1st September revised hospital discharge policy commenced with the Government funding up to 6 weeks additional care including rehabilitation and reablement from 1 September 2020 to 31 March 2021. The report provides a summary of the new hospital discharge service, the changes, activity and learning from patient experience.
Recommendations	**It is RECOMMENDED that:** **2.1 Committee members scrutinise the local response to the national Hospital Discharge Policy and the Home First approach.** **2.2 Request a report in Autumn 2021 on the outcomes of and learning from the implementation of full Home First approach across the Dorset Integrated Care System.**
Reason for recommendations	The Dorset Integrated Care System has been responsive in deploying services in order to meet the requirements of the new national Hospital Discharge Policy. The has had an impact on BCP Council residents and on the infrastructure of local services and staff working within the Integrated Care System. It is important that the Committee scrutinise the initial implementation of the Home First approach and agree how to scrutinise the long-term outcomes of this significant programme.

Portfolio Holder(s):	Councillor Karen Rampton
Corporate Director	Jan Thurgood
Report Authors	Elaine Stratman, Head of Strategic Planning and Quality Assurance Phil Hornsby, Director of Adult Social Care Commissioning David Vitty, Director of Adult Social Care Services Kate Calvert, Assistant Director, Dorset Clinical Commissioning Group Vanessa Reid, Director, Dorset Clinical Commissioning Group Kristin Dominy, Deputy Chief Executive, Dorset Healthcare
Wards	Council-wide
Classification	For Scrutiny

Background

1. The government's mandate to the NHS, published in March 2020, set a deliverable for the NHS to 'help ensure delivery of its wider priorities, which include to further improve the experience of NHS patients, working with local government to support integration and the sustainability of social care through the Better Care Fund (BCF).
2. However, Health and Wellbeing Boards (HWBs) were then advised that BCF policy and planning requirements would not be published during the initial response to the COVID-19 pandemic.
3. From 19th March 2020, integrated care systems including Dorset put into place the nationally mandated Hospital Discharge Service Policy in response to the Department of Health and Social Care publication of the Coronavirus (COVID-19) hospital discharge service requirements to enable hospitals and services to meet an expected first surge of COVID-19.
4. Because of the ongoing pressures on systems due to the pandemic, NHS England and NHS Improvement agreed that formal BCF plans did not have to be submitted for approval in the 2020/ 2021 financial year.
5. In line with this HWB areas were not expected to submit local targets for the BCF national metrics for the 2020/21 financial year but should continue to work as a system to make progress. National reporting of Delayed Transfers of Care was suspended from 19 March 2020.
6. During 2020 to 2021, additional funding has been made available to support the Hospital Discharge Service Policy, providing fully funded care for people discharged from hospital with additional care and support needs from 19 March 2020 to 31 August 2020 (also known as Scheme 1). The Council has been required to continue to fund some elements of these costs, where the Council had budgets related to hospital discharge. This included relevant budgets in the Better Care Fund for services such as reablement. From 1st September a revised hospital discharge policy and operating model replaced the Scheme 1 scheme with the Government funding up to 6 weeks reablement or rehabilitation from 1 September 2020 to 31 March 2021 (also known as Scheme 2). HWB areas were asked to place the additional funding into a pooled fund including monies that a Council would otherwise have spent including BCF funds, governed by a section 75 agreement, this additional funding is not covered by BCF national conditions.
7. HWB areas must, however, ensure that use of the mandatory funding contributions for the Better Care Fund (Clinical Commissioning Group (CCG) minimum contribution, improved Better Care Fund (iBCF) grant and the Disabled Facilities Grant) have been agreed in writing, and that the national conditions are met which are:
    a. Plans covering all mandatory funding contributions have been agreed by HWB areas and minimum contributions are pooled in a section 75 agreement.

b. The contribution to social care from the CCG via the BCF is agreed and meets or exceeds the minimum expectation.

c. Spend on CCG commissioned out of hospital services meets or exceeds the minimum ringfence.

d. CCGs and local authorities confirm compliance with the above conditions to their Health and Wellbeing Boards.

8. HWBs will be required to provide an end of year reconciliation to NHS England/ Improvement, confirming that the national conditions have been met and total spend from the mandatory funding sources and a breakdown of spend is agreed.

9. It has been confirmed by NHS England that the BCF will continue into 2021/22 and that Policy Framework and Planning Requirements for the financial year will be published in early 2021.

10. With the implementation of the Hospital Discharge Policy and the Home First model being adopted this will need to be a key consideration in developing plans for the 2020/21 financial year.

The Hospital Discharge Service (Scheme 1) Implementation March 2020

11. As stated above from 19th March 2020, the Dorset system rapidly put into place the nationally mandated model of Discharge to Assess in response to the Department of Health and Social Care publication of the Coronavirus (COVID-19) Hospital Discharge Service Requirements. This was to enable hospitals and services to meet an expected first surge of COVID-19.

12. The purpose of the policy was:

    a. to free-up hospital bed-space by streamlining the discharge process.

    b. to make staff available to respond to cases of greatest need through administrative streamlining of assessments

13. The policy also highlighted:

    a. the suspension of the CCG's duty to assess for Continuing Healthcare eligibility and;

    b. suspend the duty on acute trusts to serve an assessment notice to refer a case to a local authority.

14. In order to ensure people's needs continue to be met, the Government made available funding to the NHS to support the meeting of health and social care needs during the period, which is administered, along with local authority funding, through a pooled budget. This provided fully funded care for people either to prevent a hospital admission or were discharged from hospital with additional care and support needs from 19 March 2020 to 31 August 2020.

15. The Hospital Discharge Service commenced operating 8am-8pm 7 days a week, existing teams working extra hours and in a different way were mobilised in order to meet the increase in operating hours. The management and the co-ordination of the service was managed by a multi disciplinary central co-ordination team to identify a patient's pathway from hospital into a community based setting for onward care provision. A description of the patient pathways (and estimated percentage of those required pathways) can be found below.

16. Discharge to Assess model – pathways:

    a. Pathway 0: 50% of people – simple discharge, no formal input from health or social care needed once home.

    b. Pathway 1: 45% of people – support to recover at home; able to return home with support from health and/or social care.

    c. Pathway 2: 4% of people – rehabilitation or short-term care in a 24-hour bed-based setting.

    d. Pathway 3: 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

    Extract taken from Hospital Discharge Service: Policy and Operating Model (Published 21 August 2020)

Joint Commissioning of onward care provision for Scheme 1

17. In order to be responsive and flexible in meeting onward care provision out of hospital for Scheme1, a range of commissioning and contracting arrangements were put in place. This included the block purchasing of nearly 140 care home beds in the Council area and over 1,000 hours extra homecare provision per week for the duration of the first wave of the pandemic period.

Activity summary of patients discharged during Scheme1

18. The table below illustrates the numbers of patients being discharged from hospital that were supported by the Council with their care needs on discharge from hospital or to avoid a hospital admission.

1. A total of 889 patients were discharged from Hospital
2. A total of 87 individuals were supported to avoid hospital admission.
3. 72 patients were discharged from hospital on **Pathway 0**. a. 76% were supported with Domiciliary Care. b. 71% were known to ASC. An enhancement to their support was provided to 7% of patients
4. 462 patients were discharged from hospital on **Pathway 1**. a. 92% were supported with domiciliary care and reablement. b. 16% were known to Adult Social Care. c. An enhancement to their support was provided to 14% of patients.
5. 180 patients were discharged from hospital on **Pathway 2** a. 83% of patients were discharged into a Care Home/Block Bed. b. 38% were known to ASC and 36% required an enhancement to their current support package.
6. 78 patients were discharged from hospital on **Pathway 3** a. 97% were discharged to a care home. b. 45% were known to ASC. c. An enhancement to their support was provided to 43% of patients
7. 97 individuals were discharged from hospital, for whom we **did not have a recorded Pathway** a. 72% of patients were discharged into a Care Home. b. 22% were known to ASC. c. An enhancement to their support was provided to 19% of patients

Patient experience of the new Hospital Discharge Service during Scheme 1

19. In order to gain an understanding of patient experience of what it was like to be discharged from hospital during the first wave of the pandemic following the new operating model, Healthwatch, alongside colleagues from BCP Council undertook 21 telephone call interviews during July to Sept 2020 with patients and their families/carers.

20. The main themes from the phone interviews carried out were:

    a. The fast discharge process from hospital meant people didn't have any choice about their ongoing care.

    b. There was limited information about what was happening, especially for family members.

    c. People who went into a care home were sometimes placed inappropriately for their needs.

    d. On the whole, people and their families understood that the situation because of Covid-19 meant their choices were limited.

21. *"I didn't see that social services were involved in the discharge, but they have kept me informed where they could. I feel the hospitals could have taken a bit more time and care however, I understand that Covid had changed a lot of things."*

22. *"I was out very quickly and didn't feel very prepared. Because of Covid it made everything worse and panicky. Decision did not seem thought through because they were afraid of Covid, not enough of support from above for staff."*

23. *"Really couldn't fault the care and consideration that has been shown from start to finish. Social services picked up the case very quickly. There hasn't been a stage of the process where the social services hasn't communicated."*

24. The findings from the interviews closely mirror those found by Healthwatch England in their conversation with 590 patients experiences of leaving hospital, notably:

    a. 82% of respondents did not receive a follow-up visit and assessment at home and almost one in five of these reported an unmet care needs.

    b. Some people felt their discharge was rushed, with around one in five (19%) feeling unprepared to leave hospital.

    c. Over a third (35%) of people were not given a contact who they could get in touch with for further advice after discharge, despite this being part of the guidance.

    d. Overall patients and families were very positive about healthcare staff, praising their efforts during such a difficult time.

    e. Around a third (30%) of people faced an issue with delayed COVID-19 test results, potentially putting family and carers at risk, or in a care home, other residents and staff.

25. Lessons learnt from the period have been used to inform the future model of Home First to develop a sustainable long term approach to the programme of work.

Financial Summary of Hospital Discharge Service for Scheme 1

26. The table below shows the total cost of care that BCP Council has claimed from the £1.3bn government funding for the period 19 March to end of November.

27. People under this scheme are now being phased out on a first in first out basis returning to their normal funding arrangements whether it might be self funding, health funded or Council funded. This scheme closes on 31 March 2020.

Hospital Discharge Scheme1	19 March - November
	£000
Care homes	8,199
Home care	3,946
Community Equipment	588
Staff - Care and Assessment	238
Less BCP Council contribution to pooled budget	(500)
Total	**12,471**

Lessons Learnt from the Hospital Discharge Requirements during Scheme 1

28. In order for the hospital discharge service to be sustainable, the set up of the service needed to be reviewed. This included:

    a. Re-organising staff into new teams, these were staff from the hospital social work service, community teams and Brokerage service into two teams referred to as Single Point of Access and "One" Teams.

    b. Mapping and identifying gaps in services, including evaluating what current services are available in order to inform future strategic commissioning intentions.

    c. Ensuring there was better information available for patients and their families and carers, and that information is also available in accessible formats

d. Ensuring the commissioning of services is undertaken in a co-ordinated way as a system to meet demand.

e. Undertaking a review of therapy led services is needed to look at how Therapists can be utilised more efficiently to support people at home.

f. Developing a data Intelligence dashboard for Home First detailing activity and demand within the system; but also consideration of one case management system for tracking Home First patients and activity to ensure one version of truth.

g. Continuing to involve patients and stakeholders to understand their experience of the Home First Service.

h. Continuing the work of Community Hubs and teams working with primary Care Networks to identify clinically vulnerable patients using data from population health management tools.

The Home First approach and revised national policy/ operating model (Scheme2)

29. A review of the hospital discharge service took place in June 2020 as it was recognised that to make the service sustainable, there needed to be a review of the model, including the infrastructure of services across Dorset for admission avoidance and supported hospital discharge.

30. Subsequently the Dorset 'Home First' programme was established in July 2020, with a vision to implement an integrated Home First solution focussing on the enablement of people to achieve their health and social care outcomes in the community. Being flexible and dynamic with a rapid response to meet the changing needs of Dorset's population with the ultimate aim of a person only receiving acute hospital care when needed, for the period that they need it, with a swift and supported discharge home.

31. On 21st August 2020, the Department of Health and Social Care published a revised policy and operating model for hospital discharge.

32. The key points set out:

    a. What a hospital discharge service operating model should look like. It replaced the 19th March 2020 Hospital Discharge Service Requirements.

    b. That the government has provided funding, via the NHS, to help cover the cost of post-discharge recovery and support services, rehabilitation and reablement care for up to 6 weeks following discharge from hospital.

    c. That the discharge to assess model will be fully implemented across England operating 8am-8pm 7 days a week and from 1 September 2020, the government decided that social care needs assessments and NHS Continuing Healthcare (CHC) assessments of eligibility should recommence.

33. In order to meet the new and mandated requirements, the Home First Programme focused rapidly on agreeing and delivering a new service model to meet the requirements of the revised policy and operating framework. Existing teams and services were utilised, working in a different and more integrated way.

34. The purpose of the revised approach is to rapidly free acute hospital beds to create the capacity needed to manage the treatment of patients infected with Covid-19. The model moves much of the assessment, rehabilitation and care planning activity that has historically been undertaken in a hospital setting prior to a patient being discharged to a community setting. Patients are discharged when they no longer meet the criteria to reside in hospital, and consequently with a higher level of needs, to their home or an interim community hospital or care home. Following discharge, primary care, therapy services, community nursing and adult social care will provide a short-term recovery and assessment service before the patient is then transferred to long term care services.

35. The guidance also set out that:

    a. All assessment for ongoing care will happen outside of Acute hospitals with a multi-agency single point of access (SPA) to co-ordinate discharges. Patients will be passed to the SPA and onwards out of hospital immediately that they are considered medically ready for discharge.

b. Following discharge, up to 6 weeks of funded recovery care will take place with a focus on rehabilitation, reablement and multi-disciplinary planning for longer term care.

c. Therapy and social care staff will be moved out of hospital settings into a multi-agency community team to manage the immediate post-discharge care and support.

d. The expectation is that 95% of people being discharged will return directly home

36. For the Dorset and BCP Council areas, a multi-agency Single Point of Access (SPA) has been established to rapidly match patients at the point of discharge to services. Complementing the SPA, a multi-agency "One Team" has been set up to provide up to six weeks of rehabilitation, recovery and assessment. This model again operates seven days per week and from 8.00am to 8.00pm. BCP Council Adult Social Care has contributed to these two teams by transferring staff from the hospital social work service, community teams and Brokerage service into the SPA and One Team. The extended operating hours have necessitated additional staffing costs which have been recoverable against the national £1.3 billion funding arrangement until August 2020, but this is not the case beyond August.

Governance

37. The Dorset Integrated Care System has established a Home First Programme Board and Delivery Group to implement both the Hospital Discharge Guidance requirements and a sustainable long-term approach to ensuring that residents receive assessment, treatment and care whenever possible in their own homes.

38. There is a Commissioning Working Group as part of the Home First Programme which is working to ensure that services are commissioned across health, social care and the voluntary sector to support the Home First approach in the short and longer term.

Financial Summary of Hospital Discharge Service for Scheme2

39. From 1st September, the Hospital Discharge Programme Scheme 2 was introduced, the funding covers cost of care only (staffing costs cannot be included) and for a much shorter period of time from the discharge date to the needs assessment date up to a maximum of 6 weeks.

The estimated cost for BCP Council is in the region of £650,000 per month. Funding is only to be used for activity that is over and above that normally commissioned by CCGs and local authorities.

Commissioning

40. During October, additional hours of rapid response services were commissioned in order to support people at home on their immediate discharge from hospital. BCP Council has also been working to increase the number of home care providers who are providing care at the Council hourly rates – particularly in the Bournemouth and Christchurch areas, where there has been insufficient supply to meet demand.

Summary of financial implications

41. The Government provided £1.3bn funding to the NHS to support the enhanced discharge arrangements to support the Hospital Discharge Service Policy, providing fully funded care for people discharged from hospital with additional care and support needs from 19 March 2020 to 31 August 2020. The Council has contributed existing hospital discharge revenue funding alongside the NHS funding. This included relevant budgets in the Better Care Fund for services such as reablement.

42. With the changes to the Hospital Discharge Service Policy (Scheme 2) coming into force on 1st September the Government has made available £588 million to support the provision of free care for up to six weeks after discharge. This policy runs until 31 March 2021. This funding supplements existing council and CCG budgets. HWB areas were asked to place the additional funding into a pooled fund governed by a section 75 agreement.

43. The extended operating hours have necessitated additional staffing costs which have been recoverable against the national £1.3 billion funding arrangement until the end of August 2020. However this is not the case for the Scheme 2 funding arrangements with the Council and partner agencies absorbing these costs from September onwards.

44. The Council is facing increasing ongoing costs related to care home placements for people rapidly discharged from hospital for whom a return home is not possible.

45. In line with the government direction, BCP Council took on all commissioned care responsibilities for all hospital discharges since 19 March until 31st August 2020 including for self-funders, people with continuing health care eligible needs as well as people who would normally fall under the Council's funding criteria. All care commissioned following a hospital discharge is reclaimable from the Dorset Clinical Commissioning Group (DCCG). Up to the end of November, BCP Council has claimed £12m from the DCCG for care home placements, home care, community equipment, social care assessment, brokerage and administration staff overtime.

46. The arrangements for discharges from September until 31st March the funding covers cost of care only (staffing costs cannot be included) and for a much shorter period of time from the discharge date to the needs assessment date up to a maximum of 6 weeks. The estimated ongoing cost for BCP Council is in the region of £650,000 per month.

Summary of legal implications

47. The Hospital Discharge Policy and Operating Framework was implemented as part of the Coronavirus Act 2020 in order for the government to respond to the emergency situation caused by COVID-19 pandemic and manage its effects. The legislation contains temporary measures that either amend existing legislative provisions or introduce new statutory powers aimed at mitigating the impacts of the pandemic during the "emergency period".

Summary of human resources implications

48. In order to meet the requirements of the Hospital Discharge Service Operating model, staff have had to adapt to new ways of working, operating 7 days per week 8.00 am to 8.00pm including bank holidays working within multi-agency teams and settings. BCP Council Adult Social Care has contributed to these teams by transferring staff from the hospital social work service, community teams and Brokerage service. The Council are developing the Medium Term Financial Plan to ensure that the costs of 7 days per week working are included so that the Home First model can continue as is expected nationally.

49. The teams have been equipped with the technology and Personal Protective Equipment necessary to work in a more flexible way with reduced use of office space and a greater reliance on working from home.

Summary of sustainability impact

50. The move to widespread home and remote working with the Adult Social Care Directorate has led to very significant reductions in travel and care mileage claims for most staff.

Summary of public health implications

51. The Home First model is predicated on being able to provide proactive reablement and rehabilitation services which enable people to optimise their functioning and independence.

52. One key area for further review and strengthening is ensuring that the right level of re-ablement and rehabilitation services are available in the Home First programme and the Home First Commissioning group will lead on this review process.

53. It will also be important to ensure that there is continued work to hear the voices and experiences of people who are using the Home First Service to ensure that all is being done to ensure people's physical and mental health and well-being needs are being met.

Summary of equality implications

54. Vulnerable people and those with long term conditions, disability, ethnicity will be impacted. Prolonged stay in hospital will expose them to hospital related acquired infections and reduce mobility. Home first will have a positive impact on getting people home. The policy applies equally to all equality strands.

Summary of risk assessment

55. A risk is that people do not get access to therapy led interventions which enable their optimisation, functionality and independence. The Home First Commissioning Group will be undertaking a review of reablement and relevant intermediate care services in order to develop long-term commissioning plans to address this risk.

56. While there is a national expectation that the Home First model will continue to be implemented nationally, the current funding arrangements for Scheme 2 will cease at the end of March 2021 so local partners will need to agree how the costs of the approach can be met in the future. The necessity of enacting rapid and substantially changed responses to hospital discharge in to Wave 1 and Wave 2 of the pandemic has meant that more people have been placed in higher cost residential placements than in previous years. This will have a financial impact on the Council in 2021/22 and potentially beyond and work is being undertaken to ensure that this financial impact is accurately reflected in BCP Council's Medium-Term Financial Plan.

Hospital Discharge Service: Policy and Operating Model (Published 21 August 2020)

Hospital Discharge Service Policy and Operating model

Better Care Fund: Policy Statement 2020 to 2021 (Published 3 December 2021)

Better Care Fund Policy Statement

Leaving hospital during COVID-19- Healthwatch England (Published 27th October 2020)

Healthwatch England Report

Appendices

Appendix 1: Healthwatch Dorset report

Appendix 2: Better Care Fund Schemes, BCP Council Health and Wellbeing area

Appendix 1

Learning from people's experience of leaving hospital during Covid-19

Due to the COVID-19 pandemic, the way people are discharged from hospital has changed. We wanted to find out how the system is working and what the experience has been like for people who are leaving hospital and going into care.

Together with BCP Council Adult Social Care team we supported the design of a short patient experience survey and Healthwatch Dorset offered to carry out phone interviews with people who gave their consent to take part.

We carried out 21 phone call interviews, July to Sept, with people and their families/carers, who left hospital during Covid-19 and went on to receive care in their own homes or in a care home. The phone interviews were booked by the BCP Council Adult Social Care team, so people knew we were calling them.

We're also planning to carry out more phone interviews, in October, with people who left hospital and received ongoing health services, re-ablement/physio etc at home or continuing healthcare.

The main themes from the phone interviews we've carried out so far are:

- The fast discharge process from hospital meant people didn't have any choice about their ongoing care.
- There was limited information about what was happening, especially for family members.
- People who went into a care home were sometimes placed inappropriately for their needs.
- On the whole, people and their families understood that the situation because of Covid-19 meant their choices were limited.

Here's some quotes:

"The care home was quite inadequate. When my grandmother was discharged, she was having issues in memory and the care home wasn't set up to handle this. We felt that we were not being communicated with properly. She had a mini stroke and was sent back to hospital and we were not communicated with. She is now in a different care home."

"I didn't see that social services were involved in the discharge, but they have kept me informed where they could. I feel the hospitals could have taken a bit more time and care however, I understand that Covid had changed a lot of things."

"I was out very quickly and didn't feel very prepared. Because of Covid it made everything worse and panicky. Decision did not seem thought through because they were afraid of Covid, not enough of support from above for staff."

"I felt like I was dumped and without the proper equipment and proper precautions. Living alone with daughter. I have a care package and it was not what was agreed in hospital."

"Really couldn't fault the care and consideration that has been shown from start to finish. Social services picked up the case very quickly. There hasn't been a stage of the process where the social services hasn't communicated."

Appendix 2 Better Care Fund Schemes, BCP Council Health and Wellbeing area

BCP Council working in conjunction with local NHS providers and the wider care market invest BCF allocation under five operational schemes as detailed below**:**

Scheme 1- Maintaining Independence

Information, advice and early help is supported through joint commissioning of the digital online offer "My Life My Care" which is widely promoted and has been rolled out and supported by health and social care staff across the BCP Council area.

Support to self funders is also funded through the BCF pooled budget. It has been acknowledged by acute providers and the council that support to those who fund their own care has a positive impact on reducing length of stay in an acute bed.

We continue to commission a PAN Dorset Integrated Community Equipment Service through a pooled budget, with lead commissioning responsibility held by BCP Council.

The use of the Disabled Facilities Grant provides adaptions within the home.

Carers Services

Priority has been to ensure Carers are receiving consistent services across the conurbation including:

- Supporting the early identification of carers, including self-identification
- Ensuring carers receive relevant and timely information and advice about their caring role
- Developing the workforce to understand carers' needs, improve identification of carers and value their contributions
- Involving carers in local and individual care planning
- Enabling carers to fulfil their educational and employment potential
- Providing personalised support for carers and those receiving care
- Supporting carers to remain safe and healthy
- Delivering equality of services by commissioning carers services in a joined up way
- Ensuring that carers rights are recognised at the same level as the cared for person.

Early Supported Hospital Discharge

We continue to work with acute hospitals in planning for safe discharge into community settings including:

- Enabling provision of 7 day high quality integrated discharge services linking closely with acute hospitals for safe discharge into community settings.

- Delivering reablement and rapid response services to support adults maximise their independence on discharge from hospital, including the use of interim care home placements

Integrated health and social care locality teams

The integrated health and care partnerships across the BCP Council area are continuing to provide and further develop quality services in line with the primary care networks. Significant investment is being directed in developing rapid response services in order to deploy rapid intervention, treatment and monitoring of patients that have an immediate and/or escalating need.

Moving on From Hospital Living

This relates to providing integrated personalised care for people with complex needs who moved on from long stay hospital accommodation.