Better Care
Delivering Better Care in Brighton & Hove

Better Care Plan

2016/17

NHS
Brighton and Hove

Brighton & Hove City Council

Contents

Contents

Chapter 1 - Introduction and Context

Background

The Brighton and Hove Better Care Plan was co-produced by health and care partners in 2014. It was the product of extensive partnership work supported by NHS IQ and outlines our collective vision for the delivery of integrated care across the local health and care system.

This document provides an update on what has been achieved so far and describes how we plan to broaden our ambition from a focus on frail and vulnerable to a whole population and whole system approach in line with the aspirations set out in the Five Year Forward View.

National Context

The funding gap within the NHS and Local Authorities' Social Care Budgets requires unprecedented system change. The Better Care initiative forms part of a national strategy to support the development of place-based commissioning and joined-up care pathways to improve the integration of care for people in England.

The planning guidance for 2016/17 reiterates the commitment to Better Care and aligns it to the delivery of the five year forward view.

Local Strategic Context

A Challenged System

During 2015/16 the local health and care system has faced significant performance challenges. Access to emergency care services has been below the required standards, people have faced long waits for planned care services and there have been an increasing number of people whose transfer from hospital has been delayed. Improving the performance against key national and local targets is of paramount importance to the local system and as such our plans focus on the dual themes of delivering short term recovery whilst laying the foundations for the longer term models of care which will ensure sustainable delivery of high quality health and care services in the future.

The financial context over the next 4 years is extremely challenging. Adult social care has already delivered £16 m savings over the previous 5 years. Further savings of £7.14 million were agreed for 2015/16 as part of the Councils budget setting. Over the next 4 years we are currently anticipating delivering a further saving of £21.9m as part of the 4 year integrated service and financial planning process to support the Council to reduce the budget gap.

Further enhancement of partnership working through Better Care will progress the integration of health and social care services, mental health services and children's health services to ensure we are achieving the best value for money from the public purse and to deliver better outcomes and improved experiences for our population.

The ambitions for the diverse population of Brighton and Hove are the same across the organisations; a desire to promote and improve wellbeing in individuals and support them in actions to prevent them becoming unwell. For those who are in need of support and help in living we will commission services that will support independence, personal choice and control.

Our Population

The population of Brighton and Hove is distinctively different from that of most cities in England, it has lower proportions of people aged between 65 and 74 years old and children, and a higher proportion of adults aged between 19 and 44 years old. There is also an unusually high proportion of students and Lesbian Gay Bisexual Trans residents. This type of population is classed as a 'Sphere population' in the NHS Atlas of Variation, and is seen in only 20 cities in England.

The City currently has approximately 281,100 residents, with an equal male to female ratio.

The life expectancy for females (82.6 years) is higher than that of males (78.5), and the main all-age mortality causes are similar for both. Males experience a higher proportion of deaths due to external causes, and emergency hospital admissions.

It is estimated that the LGB communities account for 15% of the Brighton and Hove population, and there are approximately 2,760 transgender people residing here. LGBT residents have an increased risk of mental disorders, homelessness and domestic violence.

According to the latest census in 2011, White British people account for around 80.5% of the city's population, and 19.5% identify as BME. One-quarter of births within the city are to mothers who were born outside of the United Kingdom, and 8.3% of people over 3 years old do not have English as their primary language. BME residents tend to have a lower uptake of services due to a multitude of factors, including lack of cultural awareness within service delivery, and difficulties in access. Migrant residents have a higher prevalence of infectious diseases and a lower uptake of cancer screening.

There are an estimated 17,400 military veterans residing in Brighton and Hove, the majority of which are male. This is an important sub-group of the population to consider due to their increased risk of mental illness, limb loss and musculoskeletal disorders.

Around 9% of the city's population identify as carers, and it is estimated that around 2,000 a year will need treatment for stress-related illness or physical injuries sustained through their role.

There are currently 34,335 students registered with the universities of Brighton and Sussex. This sub-group have increased need for mental health, sexual health and alcohol and drug misuse services. Students account for over 10% of the local population, and a proportion choose to stay in the city after graduation each year.

Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) enables us to understand the different needs of people in different areas based on factors such as the age structure of the population, socio-economic status, ethnicity, and access to services which are all associated with particular risks to health, wellbeing and maintaining independence. It also identifies areas where we are doing well and those which need improvement.

The JSNA identifies the following key health and wellbeing issues in the City:

Increasing rates of limiting long term illness: The majority of people aged 75 years and over in Brighton & Hove live with a limiting long term illness, as do a significant proportion of those aged under 75 years (38% of males aged between 65-75 years);

Social isolation and relationship with health: There is a relationship between living in partnership and limiting long term illness. People who are in a relationship are significantly less likely to have a limiting long-term illness (21%) compared to people who are not in a relationship (separated or divorced) (42%) or widowed (56%);

Brighton & Hove has a relatively large proportion of older people living alone and potentially isolated who are more dependent upon public services. Single pensioner households are higher than average and the majority of people aged 75 or over live alone; of those living alone, 34% are male, 61% female;

High levels of mental health & substance misuse (drugs and alcohol): The City has almost twice the national suicide and undetermined injury death rate in older people. 13% of adults have a common mental health disorder while 1% has a more severe disorder. Both of these rates are higher than average levels. 18% of adults in the city are believed to engage in increasing or higher risk drinking. Rates of alcohol-related A&E attendance and hospital admissions have increased in recent years. In addition, the city faces challenges from substance misuse. There were 1,582 clients in drug treatment during 2012. A third of this client group had been in treatment for over four years.

Homeless: We have increasing levels of homeless and housing pressure. We have seen

homelessness increased by 38% over the last three years. There is a huge inequality in terms of morbidity and mortality; the average age of death of a homeless man living on the streets of Brighton is 47 years compared with an average of 77 years for the population of Brighton as a whole. The JSNA estimates that the homeless population A&E attendance rates are 5x higher than B&H average.

Local Strategic Alignment

Our strategic vision for Better Care aligns to the clinical delivery model set out in the CCG Clinical Strategy (see page 9) and the Direction of travel for Adult Social Care (see page 18). Both models the both contain activated people and resilient communities at their heart with integrated services provided through communities of practice wrapped round the individual.

The models illustrate our ambition to move from expensive, institutional and impersonal care, exemplified by inequality, disease burden and inefficient use of resources, to a sustained, resilient and healthy population with increased independence and wellbeing and efficient services.

Providing better care through integrated services is one of the key elements of the Joint Health and Wellbeing Strategy (JHWS). The JHWS and Better Care Plan are mutually dependent and are both overseen by the Health and Wellbeing Board.

Health & Wellbeing Strategy

The HWB strategy is based on a partnership approach which recognises the contributing influences on health and inequality; these include education, housing and employment. Further to this, the strategy partners acknowledge these change ambitions are being initiated in a time of financial constraint. In response, partners in the strategy have agreed the need to “pull the resources together-not only money but staff, buildings and resources-to ensure that together we maximise the impact of what we already have”. Priorities identified for the population of Brighton and Hove are listed below.

- Reducing Inequalities across the city
- Safe, Healthy, Happy Children, Young People and Families
- Provide each individual the chance to live and age well
- Develop Healthy and Sustainable Communities and Neighbourhoods
- Provide Better Care Through Integrated Services

Achievements so far

During the first two years of the better care plan we have built solid foundations for delivery of the future model of care. We have a strong and established governance structure, a clearly articulated collective vision and have delivered the majority of the milestones set out in our 2014 plan.

The 2014 plan contained 10 workstreams with 49 key deliverables. Of those 96% have been delivered and 4% are in progress. Some of our key achievements to date are described in the following sections.

Proactive Care:

The proactive service model is based around primary care with a multidisciplinary team to wrap care around a patient and carer. Proactive care is delivered by services that are arranged around clusters of GP practices, centred on the needs of the registered population. During 2015/16 we have rolled out proactive care model across 3 clusters covering a population of 150,000 (50%) and appointed 3 Cluster Pharmacists. During 2016/17 we plan to fully roll out the proactive care approach.

Homeless:

In 2014 The Homeless Integrated Health and Care Board was established under the Better Care Programme with the aim to: “Improve the health and wellbeing of homeless people by providing integrated and responsive services that place people at the centre of their own care, promote independence and support them to fulfil their potential”

This future model of care has at its centre a primary care led hub with an Multidisciplinary

outreach team working across the city in a number of spokes or settings. Health and care services are integrated within the Hub model and are proactive in their delivery to change the way care is accessed, increasing utilisation of primary and community services and reducing reliance on unscheduled and emergency care.

During 2014-2016 we have tested the effectiveness and efficiency of this model with a number of pilots. The results have been extremely positive with a reduction in the number of A&E attendances and Non elective admissions for homeless people and positive feedback from service users and those who work in the services.

Dementia:

Brighton and Hove's Joint Dementia Plan 2014/17 sets out the strategic plan for improving care and support to people with dementia and their carer's. The central aim of the plan is to increase awareness of the condition, ensuring early diagnosis and intervention as well as improving the quality of care and support for people with dementia and their carer's. Through delivery of our Joint Dementia Action Plan, the dementia diagnosis rate in Brighton and Hove has increased from 43% in 2013 to 65% in March 2016.

7 day working:

The city has a number of established seven day services. Over the past two years we have further improved this position by:

- increasing therapy capacity within our Short Term Services at the weekend thereby improving reablement input and the services' ability to accept discharges from the acute 7 days a week;
- increasing availability of night sitting 7 days a week,
- increasing capacity in our 7 day a week Community Rapid Response Team (available to respond to emergencies within the community and facilitate timely discharge)
- Strengthening our seven day crisis response for mental health

Data Sharing:

Under the auspices of Better Care the Informatics Oversight Committee was established to ensure the flow of information supported the delivery of the new models of care. Some of the achievements to date include:

- 94% of social care records use NHS number as the unique identifier
- Procured and rolled out the SOLLIS risk stratification tool
- Developed IG protocols and data sharing agreements with all relevant parties;

Partnership working with the Community and Voluntary Sector:

A successful bid enabled a "Community and Voluntary Sector Better Care Link" post to be established; this funding has facilitated embedding the CVS firmly in some of the Better Care projects , including:

- A consistent presence in early Proactive Care MDT meetings, supporting MDT members to understand the value of the CVS in a holistic care model
- Involvement with the development of the Care Coach role within Proactive care
- Consistent CVS representation at strategic meetings
- Establishment and co ordination of a Befriending Coalition across the city
- CVS leader involvement in project development- e.g. social prescribing

The post has supported CVs involvement in Primary Care Transformation, specifically in the development of GP cluster working and Locally Commissioned Services, with the mapping of clear voluntary sector "offers" in each cluster area to match demographic and clinical profiling.

In addition, the post has facilitated ongoing information and appropriate training for the CVS members, ensuring they are involved in Better Care workstreams as they develop, and has researched best practice in CVS involvement both nationally and locally.

"My Life" website:

A key objective of the CCG's Better Care work is to ensure the provision of timely, reliable information on local services, and to support self management. The My Life website (www.mylifebh.org.uk) has been developed as a partnership between the City Council and the CCG. The website has been worked on extensively to ensure it is responsive to users, and to provide a resource across clinicians, professionals, volunteers and patients, carers and the public. The site will be fully launched in May 2016.

Person Centred Outcome Measures (PCOMS):

We have developed local PCOMS based on feedback from local patients, carers and front line staff. We have PCOMS for people living with complex health needs, and for their carers, which were co designed with a core group of service user/carer representatives. The PCOMS are currently being piloted by our Care Coaches in Proactive care teams, before consideration of implementation more widely across our care groups and commissions.

Engagement in Primary Care :

We have continued to work with our Patient Participation Groups (PPGs) across the city to ensure effective engagement in Primary Care; the CCG has commissioned our local CVS infrastructure organisation to provide support to Primary Care to develop functional and effective PPGs, through existing Community Development work. Over the coming year we will further develop PPGs to work with GP clusters to ensure a collaborative, asset based, approach to Locally Commissioned Service implementation.

Performance against national metrics

Non Elective Admissions :

During the payment for performance period (Q4 2014/15 to Q3 2015/16) the reduction in non elective admissions was 3.6% against a target of 1.9%.

Reablement and rehabilitation:

The proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services indicator is measured annually based on data collection between October-March in each performance year. We therefore do not yet know the year end position for this metric.

Admissions to Care Homes:

The target set locally for reduction in permanent admissions to care homes was ambitious and has proved extremely challenging. We have undertaken a detailed analysis to determine the underlying reasons why this target has not been met. See page 22 for a summary

Delayed Transfers of Care:

Whist we benchmark well against similar areas for delayed transfers of care we failed to achieve the level of reduction we have hoped for in 2015/16. There are a significant number of plans, developed as part of our Urgent Care Plan, aimed at reducing delayed transfers of care in 2016/17, see page 24.

Dementia Diagnosis Rate

Brighton and Hove set as its local target the dementia diagnosis rate. In the last year years we have made significant progress against this target and forecast compliance by end March 2016.

Chapter 2 - Developing the Plan

System wide Engagement and Co-design

The Brighton and Hove Better Care Board has undertaken a review of local outcome measures to ensure that they are ambitious and robust enough to steer the transformational change required to deliver integrated care across the city to 2020.

A series of measures were developed by the Better Care Board for testing with local partners and community stakeholders.

An engagement workshop was held with the community/voluntary sector in February 2016 to develop a collective understanding and agreement of both the outcomes and the system change required. The event focussed on the five broad outcome domains of; prevention, proactive care, recovery and rehabilitation, personalised care and integration.

The event was attended by over 80 local organisations and has helped shape the outcomes into a series of personalised statements in each domain area. There was a strong support from those attending that the outcomes approach helped clearly articulate local expectations for integrated care. In particular there was an emphasis on how integrated care services could build local resilience and help reduce isolation, support the role of carers, and utilise voluntary and community assets to coordinate personal care

The revised set of outcome measures were then incorporated into a second event held in March 2016 with local NHS and adult social care commissioning and provider colleagues. This second event aimed to ensure that the Brighton and Hove care system has the appropriate governance arrangements in place to take forward integrated care commissioning, and provider delivery, to help address the local challenges faced.

The output of these events have shaped the Better Care Plan as described in the following chapter.

Chapter 3 – The Plan

The Brighton and Hove Better Care Plan describes our plans to deliver integrated and co-ordinated care. We have taken stock of our achievements in the first two years of the plan and recognise there are still significant opportunities to transform and redesign our community services and primary care to respond to local and national drivers for change.

During 16/17 we will develop our Integration Plan as part of our Better Care Programme, which will identify the milestones and timescales for change over the next 5 years. We have developed a set of outcomes (see appendix 1) that will steer the transformational change required to deliver the Better Care programme to 2020. The measures will contribute to realising the ambitions of the NHSE Five Year Forward View and respond to the local population and service pressures.

This work needs to be viewed in the context of a broader programme of transformation required across health and social care partners to sustain the improvement, integration and efficient delivery of services within the city. This broader programme will encompass;

- Achieving a collective understanding of current resource allocation across the health and social care system and the outcomes delivered
- Undertaking dynamic system modelling of population health and social care needs and service commissioning requirements
- An understanding of the opportunities and potential service delivery models from the local health and care provider sector
- Movement towards needs based capitated budgeting for service commissioning

The aim is to confirm a series of outcomes that anchor the Better Care Programme to deliver the system change and transformation required to deliver integrated and personalised care. The delivery of the outcomes will be embedded as a core component of the CCG 2016-17 Operating Plan and shape the system-wide requirements of the Sustainability and Transformation Plan due for summer 2016.

It is therefore important to see the Better Care programme within a wider perspective of change required to deliver city-wide transformation of health and care services that includes building personal and community resilience, and providing timely and appropriate access to urgent care.

Figure 1 – System Planning

The Better Care programme in 16/17 will continue to drive the redesign of services for our most vulnerable and frail, will form the basis of the 2020 plan for full integration and will deliver the national conditions as described in the 16/17 planning guidance.

Our Vision for Better Care

Our vision for our population is to help them stay healthy and well by providing more pro-active preventative services that promote independence and enable people to fulfil their potential.

We want services to be responsive when needed (whatever day of the week) and to be provided in a seamless and co-ordinated way thereby minimising admissions to hospital. When someone does need to be admitted to hospital our ambition is for the system to support them to recover and return home as soon as they are ready.

We see organisations working together in innovative ways to offer this more flexible, person centred approach thereby achieving better outcomes for people and making the best use of available resources.

In 2016/17 we will build on this vision and broaden our ambition from the frail and vulnerable to a whole population, place based approach.

Figure 2 – Better Care Vision

Delivery Model

Our strategic vision translates into a model of transformation and care delivered through 5 interdependent elements (Responsive community services, Safe and effective secondary care, Communities of practice, Proactive/preventative care, Reablement and Rehabilitation and) with the patient at its core, as highlighted in figure 2.

The model illustrates our ambition to move from expensive, institutional and impersonal care, exemplified by inequality, disease burden and inefficient use of resources, to a sustained, resilient and healthy population with increased independence and wellbeing and efficient services. The diagram below illustrates the delivery model which we believe will ensure our vision is realised.

Central to this is prevention through the active empowerment and engagement of patients and communities. People will thus have more choice and control and more ability to care for their own health.

The following sections describe how we will start to deliver the Better Care Vision in 2016/17.

Activated People

As described above “activated people” are key to our plans. ‘Activation’ describes the knowledge, skills and confidence a person has in managing their own health and care. People who have low levels of activation are less likely to play an active role in staying well. They are less good at seeking help when they need it, at following advice and at managing their health when they are no longer being treated.

During 2016 the CCG will produce a self-management strategy (April 16) that supports people to manage their own health; stay healthy, manage their conditions and avoid complications.

During 2016-2017 we will;

- Complete a mapping exercise of voluntary/community self-management/peer support and assimilate into local My Life information portal for the city
- Ensure promotion of self-management through primary care cluster proactive care working (care coaches/navigators).
- Utilise the CCG Locally commissioned Services framework to explore opportunities for a small number of projects for the self-management of long term conditions consistent with CCG objectives/JSNA i.e. hypertension, obesity
- Ensure that other self-care personalisation initiatives (Telecare/Living well, and Carers support projects) are effectively promoted across primary and community services
- Work with Sussex Community Trust to ensure that self-management is embedded across specialist and generalist community services and integrated into care pathways; and to review the introduction of local Telehealth initiatives

The strategy will continue to be implemented within the governance of the city-wide Better Care programme.

Proactive Care

Establishing a more proactive approach to care and support remains an integral part of this wider agenda to provide integrated care across the system. We want to connect all parts of the system, whether they are proactive or urgent, so that people receive responsive care at the right time from the right service. The capacity and system leadership from proactive care will support these wider changes in the future.

Growing evidence suggests that achieving closer integration between health and social care is key to addressing the challenges of improving outcomes for patients and reducing pressure on services, particularly acute care. This integrated approach is especially important for people with long term conditions and older people whose needs are rarely just health or social care.

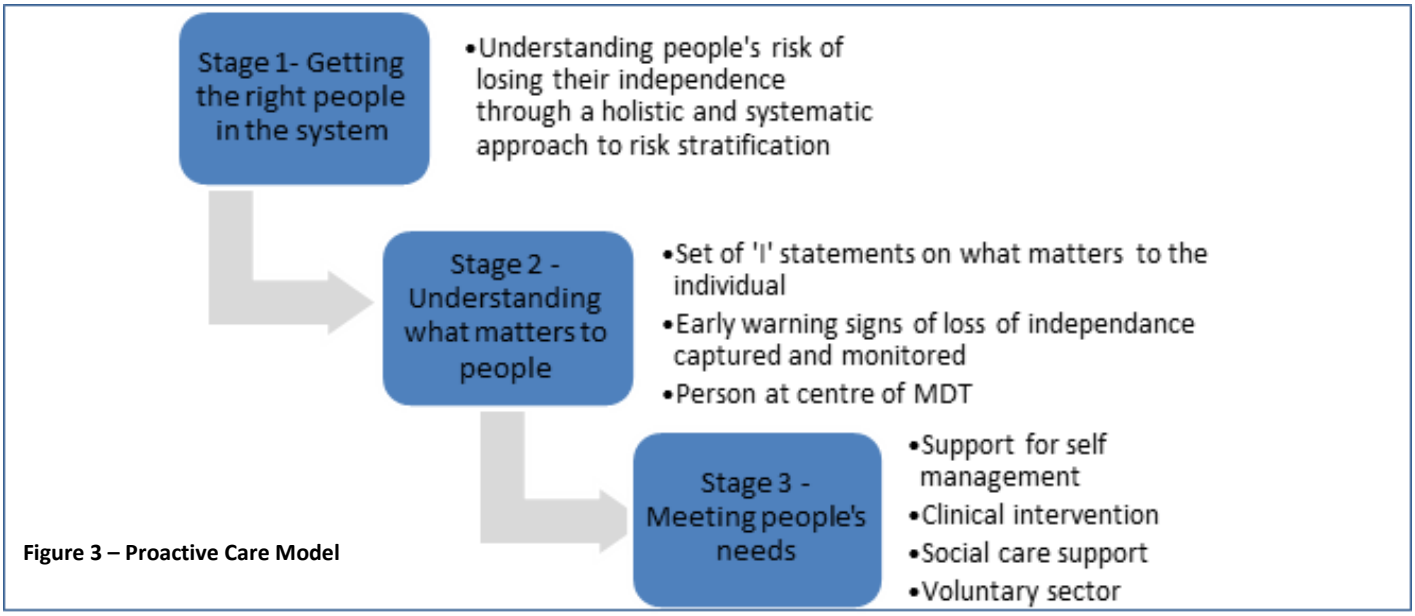


Figure 3 – Proactive Care Model

Proactive care is a model of care (see figure 3) aimed at improving the identification and management of patients at risk of deterioration in independence and an avoidable hospital admission or care home placement. It is designed to improve the health outcomes for patients based on holistic and personalised care planning, case management, and with a focus on self-management, early intervention and health and wellbeing.

It is anticipated that implementation of the service model will have a significant impact on our frail population, targeting support at 1% of the population who are high risk of loss of independence due to complex needs.

The proactive service model will be based around primary care with a multidisciplinary team to wrap care around a patient and carer. Proactive care will be delivered by services that are arranged around clusters of GP practices, centred on the needs of the registered population. General Practice will provide greater continuity of care, with more time to for patients who need it, and working in partnership with other parts of the health and care system to provide integrated care plans and service delivery.

Homeless

Improving health outcomes for the homeless population is a priority and a key element of the Brighton and Hove Better Care Plan. Health inequalities amongst the homeless population are evidenced at both a national and local level; this group has a significantly lower life expectancy-47 years old compared to 77 for the general population- and poorer health.

In Brighton and Hove homeless support services estimate that over 80 people are rough sleeping in the city currently (November 2015). In addition to this there are approximately 400 single homeless people in emergency and temporary accommodation while the city has 272 hostel places for single homeless people, with a current waiting list of 125 people.

Homeless people access healthcare differently to the general population with a greater reliance on unscheduled and emergency care. To improve health and wellbeing outcomes the CCG will deliver a new service model to increase access to, and engagement with, health and care at a primary and community level and to deliver quick and responsive interventions to manage health and care needs.

The complexity of homelessness often requires a system wide response including the resources of: health, public health, social care, housing and community safety. Current services in Brighton and Hove are not well integrated, and are frequently commissioned by setting. This configuration does not reflect the service users experience or maximise the opportunity for people to recover from homelessness and move on to independence. To meet the increasing demands of homelessness and to provide more

effective and efficient service responses, the CCG has developed a model based on a proactive approach to prevent homelessness and increase opportunities to support recovery and the journey to independence. The model has been developed with a wide stakeholder network.

This future model of care has at its centre a primary care led hub with an Multidisciplinary outreach team working across the city in a number of spokes or settings. . Health and care services are integrated within the Hub model and are proactive in their delivery to change the way care is accessed, increasing utilisation of primary and community services and reducing reliance on unscheduled and emergency care.

During 2014-2016 we have tested the effectiveness and efficiency of this model with a number of pilots. Procurement for the model will commence in April 2016 with a phased implementation during 2016-17 with the intention of having the whole fully integrated model established by 2017.

Once fully established this model will deliver a number of benefits for the individual. These will include improved health through better access to the most appropriate services and preventative pathways as well as an increase in registrations with GPs and Dentists. It also covers effective and preventative health and social care and support in moving out of homelessness. The local healthcare system will benefit in terms of reduced reliance on unplanned and emergency care and a reduction in length of stay and excess bed days.

Personalised care

Personal Care Budgets

Our plans include the proactive management of vulnerable groups and provision of personalised care and support plans. The CCG will continue to support the roll out personal health care budgets for individuals as one means of delivering a personalised agenda for care

At present the CCG have a number of clients funded under NHS Continuing Healthcare who manage their own care packages, either by a direct payment or with a third party managing the budget, and are working to develop this approach beyond this client group.

During 2016 we will continue to offer the 'right to have' a personal health budget to all people eligible for NHS Continuing Healthcare, and families of children eligible for Continuing Care. We will also develop a local plan that will confirm the extension of the personal health budget (PHB) offer to other care groups beyond Continuing Healthcare in 2017-20. This will include working with social care, NHS providers and the local voluntary/community sector to determine those cohorts of people who may benefit from a PHB from within the following care groups;

- People with long term conditions including mental health
- People with a learning disability (within the Transforming Care programme)
- Children with complex needs

The aim is to develop a detailed plan by the end of Autumn 2016 that will confirm an approach to budget setting across the agreed care groups in order that people know the amount of their PHB.

The CCG will ensure arrangements are in place to enable people to exercise choice and control over how the budget is used, and that this is recorded in a support plan and we will develop options for individuals receiving budgets that may include;

- Notional PHBs (where the budget remains within the NHS who commission services on behalf of the individual person)
- Third party arrangements where the budget is passed to a third party (non-NHS) organisation to purchase services on behalf of the individual
- Direct Payments where the budget is passed to the individual who may choose to purchase services from NHS, voluntary or private providers
- Develop arrangements for monitoring PHBs

The CCG is looking to establish a partnership approach with social care, NHS providers and the voluntary sector that establishes the most

cost effective implementation of the PHB expansion.

The plan will enable the CCG to contribute to the national target of 50-100,000 PHBs in place by 2020/21 through an aspiration to achieve at least 225 PHBs across Brighton and Hove by end 2020/21.

Carers

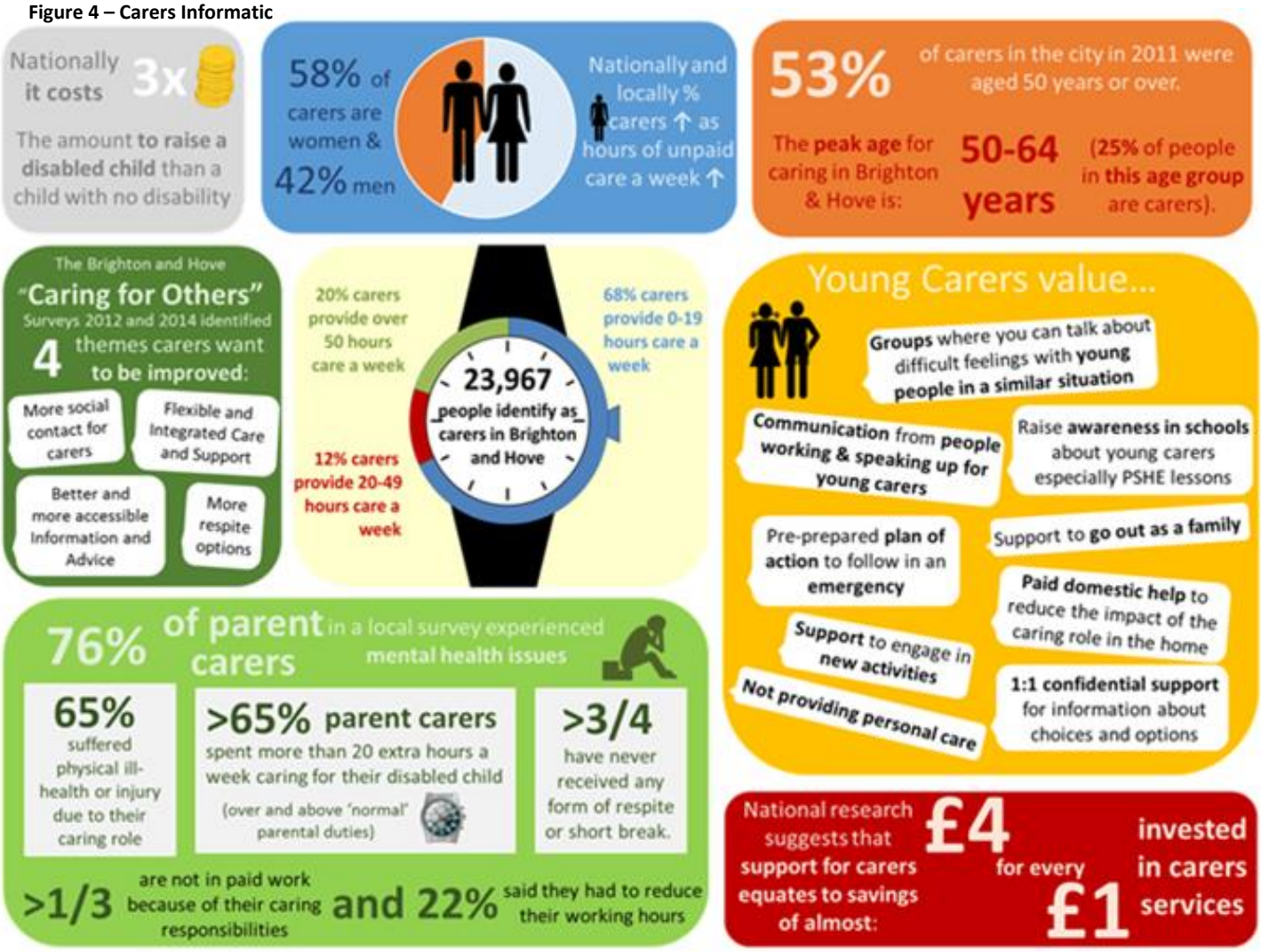
The Supporting Carers Better Care Programme is supporting informal carers across Brighton and Hove, to maintain their caring roles. Carers are defined as a person (child or adult) who is unpaid and looks after or supports someone else who needs help with their day-to-day life, because of: their age; a long-term illness; disability; mental health problems; or substance misuse. Carers play a vital role in supporting vulnerable people across the City: according to the Census (2011) just under 10% of the population in Brighton and Hove define themselves as a carer.

A new joint Carers Strategy for the City – "THINK CARER, Supporting carers through an increasingly Carer Friendly City.", is due for approval via the Health and Wellbeing Board later this year. The strategy has 5 main priorities:

1. greater carer awareness;
2. increasingly integrated support services for carers;
3. supporting carers through a tiered approach;
4. embracing a "whole family approach"; and
5. the continued development of the Carers Card (discount card for activities and opportunities for carers within the City).

The Better Care funding has enabled additional funding for the Carers Breaks and Services Budget (which provides payments to carers to fund activities and opportunities, resulting from an Adult Social Care carers assessment), and funding the ongoing jointly (ASC/CCG) commissioned range of dedicated support for

Figure 4 – Carers Informatic



carers both within the statutory and voluntary sector – from information and advice services through to carer assessments.

The funding has also enabled the piloting of four new initiatives;

- from providing free alterative care to enable carers to attend health related appointments (My Health Matter, Crossroads);
- developing a range of initiatives to support working carers or carers who wish to return to work (ASC Working Carers Project);
- supporting carers through volunteers to achieve identified goals/outcomes they wish for themselves (Carers Reabelment Project, Carers Centre);
- dedicated carer support based with the Royal Sussex County Hospital, to both raise awareness of carers within the hospital setting and to provide individual support to carers (ASC Hospital Carers Support Worker).

The evaluation of these pilots (currently awaiting end of year performance data) will feed into a wider procurement exercise for jointly commissioning services for carers. Currently we are exploring the possibility of a Carers Hub within the City, to provide information and support to carers through one website, one phone number, and one centralised triage point, behind which will be a partnership of organisations with a shared identify and outcomes for supporting carers from advice to assessment, and continue to build a carer friendly City.

Telecare

This project seeks to target and support those people experiencing a deterioration in health, who have lower level social care needs, or are struggling to cope with aspects of daily living. The project has an emphasis on early help and prevention and supports the current strategic vision (Adult Social Care Services; The Direction of Travel 2016 – 2020):

Signposting - The project has a library of community, voluntary and private sector information which is used to ensure people access the right support at the right time.

Stronger communities - One of the features of the project specification is to address isolation, support access to employment and to encourage people to fulfil their goals in their local community. Additionally, the project is partnering with community and voluntary sector organisations to support communities. Strong links have been built with colleagues at Sussex Police and East Sussex Fire & Rescue to progress several community initiatives including the Woodingdean lonely at Christmas project.

Getting people on the right track - Vulnerable people in the community or those who have recently been in hospital can find it difficult to navigate the complexities of the health & social care system. Living well supports access and pathways to the right support and interventions. The strengths based approach underpins the success of getting people back on track to healthier living.

Citizens will be in control of their own care - The telecare offer is central to self care. Telecare such as the personal alarm, medication prompts, wellbeing checks and bed and falls sensors support people to maintain independent living, backed by 24/7 remote support.

As well as supporting people with telecare services, the project works closely with other services across Brighton and Hove to help people maintain their dignity and live well, doing the things they enjoy, and getting out and about.

The project has 2 areas of focus:

- Hospital in reach: To support timely discharge from hospital and to prevent further avoidable admission to hospital

- Community support (prevention): To promote living well at home to reduce, delay or avoid the need for care and support

The core staffing of the project consists of three CareLink Care Managers. These are newly designed posts which have an emphasis on early help, prevention and integrated working. The CareLink care managers assess and install telecare themselves and carry out a strengths based conversation around maintaining Independence.

Relationship building with hospital teams, in particular the Hospital Rapid Discharge team (HRDT) has enabled effective acute referrals which has supported the flow and discharge in the hospital.

Since 24 August 2015 when the team started to take referrals a total of 215 people have been supported.

Referrals	No.
Hospital	92
Community	123
Total	215

Integrated Community Services

The CCG seeks to improve the quality of life and health outcomes for people with long term neurological conditions in the city by establishing an integrated community specialist neurological hub. Current services are configured in condition -specific silos which is in contrast to ever increasing patient profile of comorbidities demanding holistic service solutions. The hub, although primarily containing neurological community services, would form the basis of a specialist hub in the community as part of the wider integration agenda. Expected outcomes include improved patient access and quality of intervention through improved service resilience and support through shared resources and capacity.

Diabetes

The CCG awarded Sussex Community Trust a contract to deliver a 'one-stop shop' approach for Community Diabetes Service in 2015/16 with the aim of providing personalised support for patients in their local community. This integrated, consultant-led service will launch in 2016/17 and provide psychological, podiatry and dietetics support services to people living with diabetes. This service works in partnership with primary care to support patients to self-manage their condition with personalised care plans and improved access to high quality education and information.

This approach will improve health outcomes for people who have a diabetes diagnosis, as well as those at risk of developing the condition. The service will bring hospital and community teams closer together, working under a single leadership structure in collaboration with GP practices and Diabetes UK. It will support local GPs, nurses and healthcare assistants to increase skills and knowledge around the management of Diabetes in primary care.

Integrated Social Care and Health Care Home Programme

The CCG continues to develop support for improved outcomes for people living in care homes by establishing an integrated Social Care and Health Care Home Programme. This work will bring together existing projects and work; spanning commissioning, contracts and quality across NHS and city council organisational boundaries and bringing them into a single programme to jointly tackle challenges, share resources, learning and relationships to make a greater impact on the sector.

A key ethos of the programme will be developing strategic and collaborative discussions with the sectors. Through a united health and social care voice, the programme will gain greater whole sector intelligence, removing inequity and reducing variation in practice. Through enhanced engagement the sector, will be empowered to co-own some of the system wide, and in some cases societal challenges, facing care homes.

Joint Dementia Plan

In response to the Prime Minister's Dementia Challenge launched in 2012 the dementia diagnosis rate in Brighton and Hove has increased from 43% in 2013 to 65% in March 2016. Through delivery of our Joint Dementia Action Plan, agreed by the Health and Wellbeing Board, we will continue to strive for improvement in timely diagnosis to achieve and maintain the national 67% diagnosis target in 2016-17.

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

During 2016-17 we will continue to deliver against the Joint Dementia Action Plan, seeking to improve health and wellbeing, reduce social isolation and increase support to enable people with dementia to remain active in the community for longer through enhanced early intervention services and a dementia Action Alliance.

Greater coordination and integration between services supporting people with a dementia and their carers across the whole pathway forms the focus of year two of the Joint Dementia Action Plan. During 2016-17 the focus will be on improving the quality of in inpatient dementia services and drive forward integration with other services in community and voluntary sector. The CCG will support the implementation of new early interventions and action alliance services into the system and will introduce and embed the Admiral Nurses service. The Dementia Action Alliance and a range of services will meet the second part of the Prime Minister's Dementia Challenge which is to support people who have just been diagnosed with a dementia and their carer's.

Further to this there is a programme of ongoing dementia training work; identifying and supporting implementation of training gaps within the workforce (which one) and looking to roll out the shared learning outcomes to wider independent and third sector partners

The remainder of the plan is described under the headings of the national conditions.

Chapter 4 - Delivering the national conditions

There are 8 national conditions set out in the Better Care Policy Guidance 2016. The following sections describe how we will continue to deliver against the exiting national conditions and make progress against delivering the new conditions in 2016/17:

Finance

The proposed total pooled budget for 16/17 is £20,087k, which is in line with 15/16 levels. The CCG plans to maintain its contribution to the fund with a total contribution of £18,252k, which is slightly above the 16/17 minimum contribution required of £17,955k. The Council contribution of £1,834k includes £1,597k of capital grant funding. The fund will be hosted by Brighton and Hove CCG. A breakdown of the fund is contained in appendices 2 and 3.

There is a joint commitment to spending the Better Care Fund in the most effective way. If future payments are withheld because of a delay in realising the benefits of a particular scheme, but it is agreed that the scheme will still deliver the benefit, then the CCG will continue to fund that scheme.

Additional investment has been agreed to implement the proactive care model across Brighton and Hove in order to achieve the intended outcomes. It is anticipated that as the effect of proactive care is realised the investment can be offset through savings gained from a reduction in acute care activity and fewer conveyances. and ambulance activity.

The costing has been based on activity levels that target 1% of the population, with incremental roll out during 15/16 and 16/17. Full financial costs and savings for the model will be realised in year 3 (2017/18).

The CCG has built a contingency into their financial plans to mitigate against over

performance in the Acute sector relating to QIPP or Better Care. There is also a history of joint working across the local health and social care economy which will help to reduce this risk.

We have taken a cautious approach to forecasting the likely value of savings; ensuring plans are not overly ambitious. Therefore total planned savings are a relatively modest. The CCG has sufficient contingency reserves to cover any shortfall in the achievement of these savings over the next two years.

Risk sharing arrangements around contributions to the pooled fund and any shortfall in savings generated, will be fully defined as part of the S75 agreement

Protecting Social Care

All of the funding currently allocated in 2016/17 under the Social Care to Benefit Health Grant has been maintained to enable Brighton and Hove City Council to meet its statutory needs. Importance has been placed on reducing demand and finding ways to support individuals to prevent them from needing Adult Social Care Services. Where people do require services - there is an emphasis on reablement services that help people fulfil their potential.

In relation to funding this will mean:

- A continuation of existing services such as prevention of admission to hospital , early supported discharge and rapid response services;
- Spending on adult social care to meet statutory need
- Support for the independent care sector to ensure timely discharge from hospital
- Further investment in carers services including meeting the requirements of the Care Act
- Further investment in advocacy services in response to the Care Act requirements from April 2015
- Further development and investment in Information & Advice services to support the preventive approach and ensure compliance with Care Act requirements & the launch of the MyLife website

Review of first contact, assessment, review and care planning process to promote a preventive, proportionate and efficient service that can also meet the new demands placed on it through the Care Act. This is aligned to the Better Care programme and opportunities to work more creatively with all partners and people using services, including supported assessment opportunities.

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

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

The Care Act provides the statutory framework through which the Council must operate in meeting the care and support needs of adults and carers in the city. The Care Act is centred on the personalisation of social care, giving people as much choice and control as possible and establishes clear duties regarding wellbeing, prevention, co-operation between agencies, information and advice, safeguarding, carers rights, assessment and the provision of a diverse high quality social care market place. The legislation provides a positive statutory framework which supports our local aspirations but also sets out the statutory boundaries within which we must operate.

The Budget: The financial context over the next 4 years is extremely challenging. Adult social care has already delivered £16 m savings over the previous 5 years. Further savings of £7.14 million were agreed for 2015/16 as part of the Councils budget setting. Over the next 4 years we are currently anticipating delivering a further saving of £21.9m as part of the 4 year integrated service and financial planning process to support the Council to reduce the budget gap.

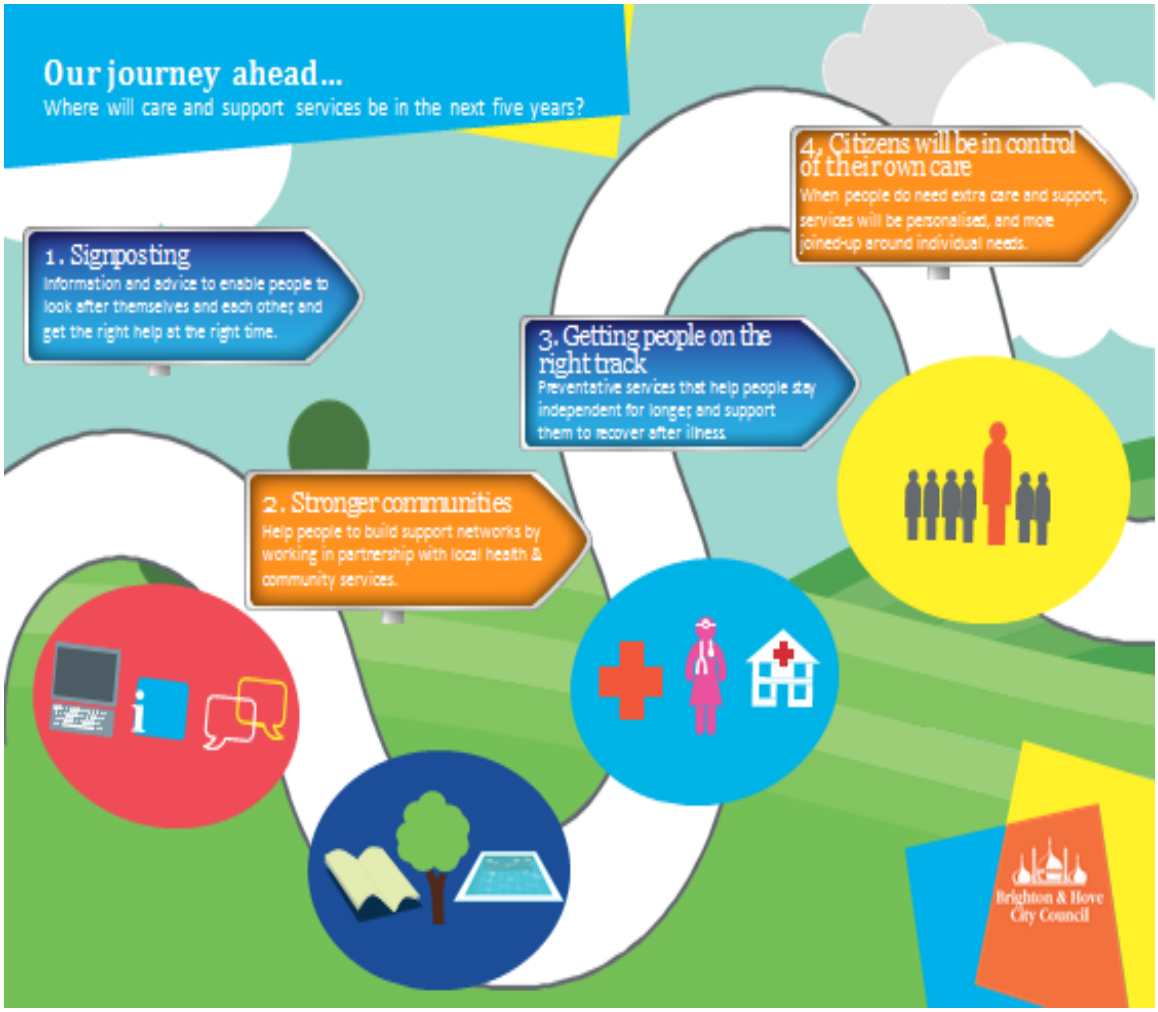
The Better Care programme provides an opportunity to help local people stay healthy and well, one element of this will involve improved co-ordination and integration of services across the health and social care sector.

Complexity of Need: Alongside increasing financial challenges and statutory duties care services will also need to respond to the potential for increased demand alongside the increasing complexity in people's care needs.

Workforce: A skilled workforce will be essential to the delivery of good quality care services in the coming years. Our current analysis indicates that we have an aging workforce in the sector with a disproportionate number of staff aged 55 years and over, there is high turnover of staff, many staff are low paid and there are also recruitment and retention issues in relation to professional staff. We are currently developing a workforce strategy that will cover the period 2016-20 in order that a skilled and stable work force is in place. This has taken full account of the Ethical Care Charter & the need to consider the National Living Wage for care providers in the city.

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

- Signposting - The provision of accessible information and advice to enable people to look after themselves and each other, and get the right help at the right time as their needs change. Good quality information and advice will be available to all to help people plan for the future, reduce the need for care services and where possible maintain independence.
- Stronger communities -Help build support networks where people live by working in partnership with local health and wellbeing services. This is rooted in the recognition that we are all inter-dependent and we need to build supportive relationships and resilient communities. We will expect to share responsibility with individuals, families and communities to maintain their health and



independence.

- Getting people on the right track - Preventative services that help people stay independent for longer, and support them to recover back to good health after illness. These services will be joined up with and delivered with our partners.
- Citizens in control of their care - When people do need some extra care and support, services will be personalised, and more joined-up around individual needs. Personal budgets and direct payments are central to this approach.

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

This is a critical factor in adult social care achieving financial balance as the community care budget is by far the biggest element of adult social care expenditure. Achieving a £21.9 million reduction in expenditure will inevitably require reductions in community care budget expenditure. It is acknowledged that delivering this vision is complex and challenging, it will require some difficult decisions and the implementation will require excellent partnership working and timely delivery plans. However there are also real opportunities for progress through programmes such as Better Care, Community Collaboration, City Neighbourhoods and Customer First in a Digital Age.

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

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

Given the context and broad vision described above the anticipated direction of travel of adult social care over the coming 4 years is as follows:

Commissioning

With regard to the commissioning of services it is anticipated that over this period;

- Services will be commissioned on a more co-ordinated and integrated basis across the Council and with other statutory partners, building on the solid foundation we currently have in place. Currently similar services can be commissioned separately by different directorates within the Council and colleagues in the Clinical Commissioning Group.
- Citizens and service users will be fully engaged throughout the commissioning process.
- A wider range of services that promote independence, are outcome focused and support a personalised approach will be in place.
- Safe mechanism will be in place so that individual support plans can be placed on line enabling accredited providers to respond creatively as to how they could best meet the persons requirements. People will also have the option to have flexible, personalised support, tailored to individual preferences without having to manage the responsibility of cash direct payments

through new contractual specifications (known as Individual Service Funds).
- We will reduce and delay the demand for long term care in the community by commissioning services that support independence and personal control
- We will further develop our understanding of a fair price for care services in partnership with the care sector.
- We will look to commission services in the city that keep people close to their family and communities when they require care and support.

Assessment Services

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

- The Councils in house assessment services will be increasingly focused on intervention and support for people with the most complex needs and those where the level of risk to the individual or others is assessed as high.
- The in house workforce will be increasingly composed of staff with a professional qualification or social. The actual number of staff employed within the Council will have reduced.
- By deploying mobile technology, for example tablet computers, our staff will be able to complete their assessments directly with people in the community, delivering a more personalised and efficient service.
- Citizens will be supported to complete assessments of need, including an enhanced on line assessment offer. The support will be proportionate and appropriate and may come from a range of sources including family, community support and the voluntary sector.
- Our approach will be an asset or strengths based one, focusing on what people can do and what they have to offer their community.
- All people who are eligible for services will be offered a personal budget and the numbers of people choosing to purchase their own services through Direct Payments will increase significantly.
- Integrated assessment across primary care and social care will be fully implemented through the Better Care Programme.
- We will enable people to live with the risks that can be inherent in living independently whilst ensuring they are safeguarded from significant harm.

Directly provided services

With regard to our in house service provision, which has relatively high unit costs, it is anticipated that over this period;

- We will cease to provide services in house where good quality services can be provided more cost effectively by others, subject to appropriate consultation and approval.
- In house services will support adult social care in meeting its statutory duties and provide services where other providers are not available
- We will review with people using services and their families whether their support plans could be provided in a more personalised and cost effective manner. As a consequence some existing in house provision could be re-provided.
- We will disinvest in our buildings based care to promote more personalised care based in the community and individuals' homes
- Our remaining in house provision is likely to be specialist and short term in nature and can evidence it is value for money.
- Changes in the provision of in house services will require careful planning and implementation so that it keeps pace with the more personalised provision of care.

Reducing care home admissions

The following actions have been taken to reduce admissions:

- Commissioners have included a more robust set of requirements in their plans to re-commission Community Short Term Services in relation to preventing admission to long term residential and nursing home care. This includes people in the community as well as those being discharged from hospital. A

report is being presented to the Health & Well Being Board on October 20th.

- Plans have been agreed to clarify and promote the pathways into the Independence At Home team for people in the community who would benefit from this reablement service.
- The review function within the council is itself subject to a review regarding how this function could be delivered more effectively. This will help to ensure that people receive timely reviews after discharge from hospital to ensure levels of support are appropriate.
- Discussions on going with housing services regarding timely access to alternative accommodation in the community.
- Further data analysis has been requested regarding self-funders who fall below the Councils financial threshold.
- The analysis also noted that other factors include
- An increase in the number of people who initially funded their own residential and nursing home care and whose funds have depleted
- The increasing complexity of need which can result in care at home costs significantly more than the cost of a residential and nursing home placement. Managers are making case by case judgements when considering such circumstances
- Potential actions to reduce the admissions into long term care residential and nursing home care.
- Renewed focus on people admitted from the community. Analysis has shown that over 70% of new long term admissions are from community settings.
- Review the reablement / community short term services offer to people in the community at risk of being admitted to long term residential and nursing home care and whether the pathways into this service are effective.
- Continue to work with housing colleagues to review the pathways between extra care and sheltered housing and residential / nursing home care.
- Review the arrangements to undertake individual reviews within 6 weeks of placement before any decisions are made about whether the placement should be permanent in nature.
- Continue to support staff in promoting an asset based approach to people's care needs and the alternative options that may assist in avoiding a long term admission to residential and nursing home care.
- Develop more robust performance reporting and analysis in relation to residential and nursing home admissions.
- Further develop existing joint working of the Integrated Primary Care Team, extending integrated working across all clusters.
- Further develop the Risk Stratification tool to enable identification of those at risk of losing independence for targeted multi-disciplinary intervention under the Proactive Care programme.

Seven Day Services

The system has undertaken a detailed gap analysis of our existing services and identified keys areas for focus in 2016/17. During 2016/17 we plan to:

- build on the Extended access in Primary Care programme by extending delivery to city wide coverage, target peak times of demand and include redirected urgent activity not just GMS
- Extend the GP in Urgent Care Centre from 11 to 7 every day to midnight
- Continue the extended hours of the community rapid response service from 7 days a week – 8am to 8pm to 10pm
- Work with partners to identify gaps in 7 day provision across the care sector

Data Sharing

The local system recognises that the opportunities provided by technological developments, and their facilitation in information sharing and management, are core to the future design and innovation in service improvement. New technologies offer significant opportunities to improve experience, productivity and quality across health and social care services. The CCG and local authority will begin

the implementation of the Digital Roadmap during 2016-17.

During 2016-2017, we are preparing the foundations to ensure effective development and delivery of the national 2020 vision. To do this, we have taken steps to ground the prerequisites for successful delivery in our operational thinking. These enablers include a CCG informatics vision and strategy embedded within our commissioning pathway; the two are intrinsically linked and to deliver this ambition effectively the CCG recognise the need for resources of expertise, seniority, and time. Assurance of these innovations will need effective governance and coordination mechanisms, particularly across organisations.

This organisational bedrock will support the streamlined care delivery which makes effective use of information and technology wherever there is a benefit. This will include a view only portal for professionals across organisations to access patient records held in multiple organisations. It is envisaged that these professionals will share working space to record and work together on a subset of care plans for patients with complex needs or a high level of risk. This will be facilitated by an effective management / intervention planning toolset. Care and support will be improved through the effective use of specialist expertise through teleworking initiatives. For individuals there will be a personal portal to view records, enter and access information.

Joint approach to assessments

Joint assessments are being implemented through the local proactive care programme. City-wide coverage of the programme will be implemented across all primary care practices by August 2016. An agreed approach to developing Personalised support and care planning will be developed, and tested with proactive care multi-disciplinary teams during 2016-17.

The proactive care model to joint assessments and care plan conforms to the terms of the national condition.

Impact on providers

The impact on the acute hospital has been quantified and included in the 2017/18 contract negotiations and subsequently in the 17/18 contract.

We estimate that our total expenditure on non-elective admissions and A&E attendances for Brighton and Hove residents and Brighton at Sussex University Hospital Trust is £42m million per annum.

The Better Care Fund is predicated on the assumption that providing more integrated and pro-active care in the community will reduce the need for hospital based emergency and planned care. Brighton and Hove has comparatively low rates of emergency hospital admissions and we have shown a downward trend over recent years against the national trend of increasing rates. We have achieved this through substantial investment in out of hospital services and we are in the lowest quintile nationally for non-elective admissions and for non-elective admissions for primary Ambulatory Care Sensitive conditions. Given our relative performance in the acute sector and the investment already made in out-of-hospital services the scope for extracting further savings from the acute sector in the short term is more limited. However our Better Care Plans for Brighton and Hove involve substantial redesign of the whole system. This transformational whole system approach to integration will reduce some of the existing inefficiencies created as a result of multiple barriers between services.

We estimate that a reduction of 849 non elective admissions could be realised in 2016-17. We also expect that by more proactive management of people with complex needs and long-term conditions we can avoid a number of elective procedures and realise efficiencies from working in a more integrated way across acute and primary/community care.

We are able to pump prime the changes in the acute and community sector required to deliver more proactive care in part by using monies from the 2.5% non-recurrent expenditure fund within the CCG in 2014/15 and 2015/16 in order to release savings in 2015/16 and beyond to fund the Better Care programme on a recurrent basis.

Delayed transfers of Care

Baseline Assessment

Historically Brighton and Hove have benchmarked well against our ONS cluster and England average – in 2014 Brighton and Hove had the third lowest DToCs in our peer group and less than the England average. However recently performance has deteriorated and % acute beds occupied due to a delayed transfer of care has risen from 2% in December 2015 to 4% in March 2016.

In order to address the increasing acute delays and to maintain the reduction in mental health delays we have developed the Urgent Care System Plan with partners. The keys elements of the plan which relate to reducing DToCs are listed below.

Plan to Reduce delayed Transfers of Care

Plan is broken down into the following areas:

1. Improving Hospital Discharge
2. New models of Care for Community Beds
3. Discharge to Assess
4. Managing escalation

This plan has been developed under the auspices of the Systems Resilience Group and will continue to form a key element of our Urgent Care Improvement Plan.

Improving hospital discharge

This workstream will ensure improved discharge Planning by implementing Choice and discharge Policies, implementing discharge checklist 24-48 hours prior to transfer, ensuring every ward uses the discharge booklet, implementing Safer Bundle on every Ward and the use Frail Safe

New Model of Care for Community Beds

The preferred service model for patients is to receive rehabilitation and reablement within their normal place of residence but the CCG recognise that for a few patients this is not always possible/desirable and some bedded facilities will be required.

The model the CCG is procuring is a more responsive and appropriate model of care for step up/step down and rehabilitative care beds that is consistent across the Local Health Economy. The current model has experienced delays to admission and higher length of stays and it is expected that the new model will increase the flexibility and flow through the system.

To deliver this model the CCG is bringing together a range of partners under a single contract with a lead provider accountable for all aspects of the service delivery. This model will expand the availability of step up care for primary and social care services and prevent avoidable admissions to acute care. Flow through the community bed service will further be optimized by cross system decision making, a clear focus on re-ablement, (aligning expected discharge dates to treatment goals) and access and discharge processes standardized. The acceptance of new referrals and patient discharge protocols will operate seven days a week.

This model will support optimised throughput and timely onward referral and discharge, thereby reducing lengths of stay across all bedded units. This new model of care will be in place in April 2017.

Discharge to Assess

This approach to discharge recognises it is more appropriate to assess the future care and support needs of people who are medically ready to leave hospital within their own home, where they are familiar with the environment and are likely to feel more confident to engage in their own recovery and rehabilitation planning.

This model has been in operation since early 2015 with a dedicated team of qualified therapists and healthcare assistants. The CCG plans to extend this programme to enable 15 discharges per week initially, increasing to 30 plus per week during 2016/17.

The service will be integrated with our Community Rapid Response Service to ensure a consistent rapid response for both admission avoidance and supported discharge. This will include support provided by SCT Intermediate Care Services and Independence at Home.

Managing Escalation - Shrewd System

We have implemented a new system to improve the CCG's capacity management and support system resilience by providing a real time view and highlight of system pressures.

Chapter 5 - Governance and Performance

Governance

During 2015/16 the Better Care Board has continued to provide system leadership and coordination of the programme. The Board has been supported by a Better Care Delivery Group of senior health and social care partners to oversee the implementation of the joint commissioning and pooled fund arrangements, and the delivery of local services changes.

In addition a Better Care Finance and Performance Group, and Programme Management Office arrangements support the Delivery group in monitoring and reporting to the Better care Board on a monthly basis.

Furthermore – during 2015 local providers established an Integrated Provider Board to consider alliance working and cross organisational working to deliver integrated and personalised care. The Board includes NHS and social care providers, primary care and community /voluntary sector. Senior leaders attend both the Integrated Provider and Better Care Boards.

As described in chapter 2 - the Better Care Board has considered the ambition of the programme and the outcomes we are trying to achieve in light of; our local system challenges, the NHS planning guidance requirement for every area to have an agreed plan in place for March 2017 for better integrating health and social care by 2020, and local authority devolution considerations.

There is a commitment to a phased approach to expand the scope of the integration programme that covers the whole city population. This will require some refinement of existing governance arrangements. The Better Care Board will continue to comprise senior system leaders amd coordinate the implementation of the programme with the support of formal provider and commissioner delivery arrangements reporting directly into the Board

Measuring Success

The local approach to measuring success is to focus on delivery of individual goals and improved outcomes underpinned by metrics and finances to determine whether the expected impact has been achieved. The tab le below shows the four levels of measurement:

Measure	What does it tell us
Individual Goals	Do people achieve the goals they set?
Outcomes	Are we delivering improved outcomes?
Metrics	Are we seeing the right number of people? Are there any unexpected consequences in the rest of the system or population?
Finances	Are we delivering within budget? Are we delivering the expected return on investment?

Individual Goals

Working with Care Coaches individuals will describe what goals they home to achieve and attainment of these goals will be measured by the proactive care programme. The Care Coached enter the agreed goals in to the Clinical system and update progress against them at each contact. Regular reports are

provided to the Steering Group and Better Care Board.

Outcome Measures

The Better Care Board agreed that the success of the programme should be measured against a set of locally developed Person Centred Outcomes Measures (PCOMs), and a series of population based Outcomes for Integrated Care.

The PCOM were developed with groups of local service users/carers to ensure the new models of care are delivering improved outcomes for those individuals that use them. The measures are:

1. I have a positive relationship with my GP and care team and feel involved in decisions
2. I am as mobile and physically active as I can be
3. I can get out of the house and about (including access to transport)
4. I have strong social connections. I am not lonely (friends, family and like minded people e.g. peers with similar experiences of caring)
5. I have a happy life and feel hopeful (not depressed)
6. I get the support I need with everyday living (including home care, a personal assistant, suitable housing)

The overall success of our Better Care programme will also be measured against a series of population based system-wide outcomes which cover all aspects of the programme – see Appendix 1. These outcomes were developed through engagement with a range of community/voluntary sector groups and stakeholders. A local workshop was held in February 16 to shape the measures and ensure they reflected a personalised approach to service delivery and monitoring.

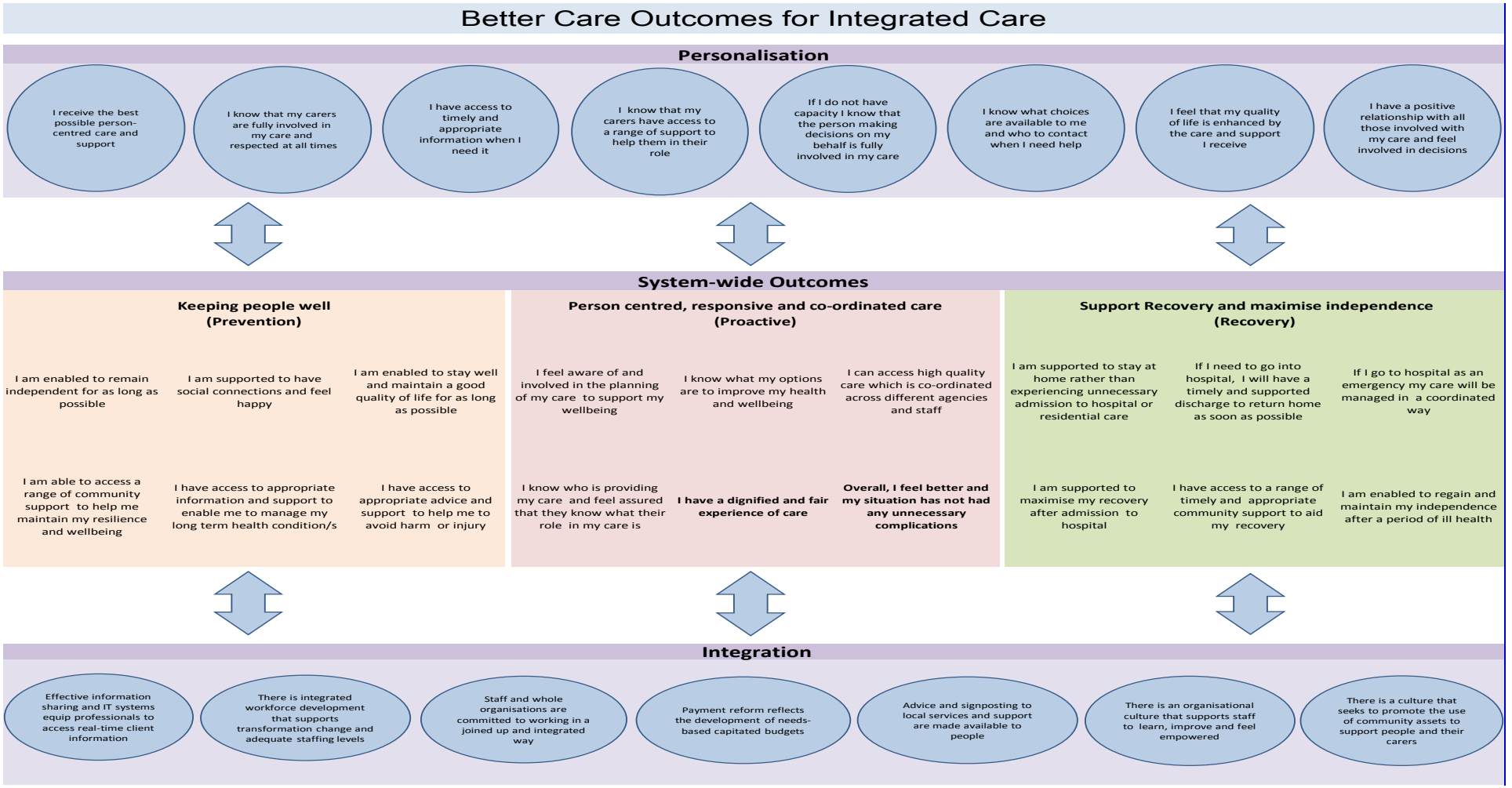
A second workshop of the local commissioning and provider leadership community (March 16) endorsed the use of the outcomes for monitoring the programme, but suggested they should be reviewed to ensure that they reflect the increased scope and population coverage of the integration programme. This refinement will be completed by June 16 at this time we will also agree our local targets against the national metrics.

Conclusion

The Better Care Plan 2016-2017 confirms the commitment the local system has to meeting the challenges set by the Five Year Forward View. While acknowledging the challenges the local system has faced in terms of the performance the plan provides solutions to the attainment of a recovered and a sustainable future model of care which is set in the context of the emerging themes of the Sustainability and Transformation Plan.

Although described in separate sections the totality of our 2016-2017 plans are co-dependent, driving service and workforce development towards a model of sustainable, high quality and truly, integrated partnership working. Key to the success of this delivery is the development and support of the engaged and empowered patient. By coming together, as organisations and individuals, and making fundamental shifts in our perception of models of service delivery and whole system engagement this approach aims to deliver a local health and care service that engenders equality, improvement, independence and engagement.

Appendix 1 – Better Care Outcomes



Appendix 2 - Finance Schedule

2016/17 Better Care Pooled Fund

	CCG £	BHCC £	16/17 Total £
Integrated Delivery Workstream	10,507,212	20,000	10,527,212
Personalisation Workstream	2,566,274	217,510	2,783,784
Protecting Social Care Workstream	4,398,000	1,597,000	5,995,000
Keeping People Well	781,000	0	781,000
TOTAL	**18,252,486**	**1,834,510**	**20,086,996**

CCG BCF Allocation

Additional BCF 16/17 Allocation	5,631,359
2016/17 Mandated Transfer from Baseline	12,323,630
Minimum Contribtion to BCF	17,954,989
Additional Contribution to BCF	297,497
Total Contribution to BCF	**18,252,486**

BHCC BCF Allocation

Capital Grants	1,597,000
Council Budget	237,510
Total Contribution to BCF	**1,834,510**

The proposed total pooled budget for 16/17 is £20,087k, which is in line with 15/16 levels. The CCG plans to maintain its contribution to the fund with a total contribution of £18,252k, which is slightly above the 16/17 minimum contribution required of £17,955k. The Council contribution of £1,834k includes £1,597k of capital grant funding.

Appendix 3 - Detailed Finance Schedule

	CCG	BHCC	16/17 Total
	£	£	£
Integrated Delivery Workstream			
Proactive Care (Primary Care)	1,500,000		1,500,000
Additional Care Managers working across the City localities 7 days pw	138,000		138,000
Integrated Primary Care Teams (SPFT)	98,573		98,573
Integrated Primary Care Teams (SCT)	7,993,639		7,993,639
3 Social Workers in IPCT's	121,000		121,000
Incentivising care homes and homecare providers to respond 7 days pw	69,000		69,000
Homeless Model	587,000	20,000	607,000
Total Integrated Delivery Workstream	**10,507,212**	**20,000**	**10,527,212**
Personalisation Workstream			
Community Equipment Service	1,338,784		1,338,784
Carers Reablement Project	40,000		40,000
Alzheimer's Society – Information, Advice and Support for Carers	50,000		50,000
Alzheimer's Society – Dementia Training for Carers	10,000		10,000
Sussex Community Trust – Carers Back Care Advisor	34,000		34,000
Amaze – Carers Card Development	10,000		10,000
Carers Centre – Adult Carers Support	128,000		128,000
Carers Centre – Young Carers Support	32,000		32,000
Crossroads – Carers Support Children and Adults	47,000		47,000
Carers SDS Breaks and Services – spot purchase budget	25,000		25,000
Carers Centre – End of Life Support	18,000		18,000
Amaze – Parent Carers Survey	1,000		1,000
Dementia	22,000		22,000
Carers SDS Breaks and Services – spot purchase budget	100,000		100,000
Crossroads – Carers Health Appointments	75,000		75,000
Working Carers Project - ASC Supported Employment Team	60,000		60,000
Hospital Carers Support – IPCT Carers Support Service	54,000		54,000
Carers Support Service - Integrated Primary Care Team (ASC Staff)	186,350		186,350
Carers	335,140	217,510	552,650
Total Personalisation Workstream	**2,566,274**	**217,510**	**2,783,784**
Protecting Social Care Workstream			
Maintaining eligibility criteria	2,904,000		2,904,000
Protection for Social Care (Capital grants)		151,000	151,000
Disabled facilities grant (Capital grants)		1,430,000	1,430,000
Additional social workers for Access Point	70,000		70,000
Telecare and Telehealth (Capital grants)		16,000	16,000
Additional call handling resource for CareLink out of hours	35,000		35,000
Additional Telecare and Telehealth resource	200,000		200,000
Protection for Social Care	1,189,000		1,189,000
Total Protecting Social Care Workstream	**4,398,000**	**1,597,000**	**5,995,000**
Keeping People Well			
Care Navigation Service	120,000		120,000
Befriending - Neighbourhood Care Scheme	48,000		48,000
Keeping People Well	282,000		282,000
Dementia Plan	250,000		250,000
2 Band 6 RMNS for care home in reach / Dementia Patients	81,000		81,000
Total Keeping People Well	**781,000**	**0**	**781,000**
TOTAL	**18,252,486**	**1,834,510**	**20,086,996**