Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Living Well project update

1.1 This paper can be seen by the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 7th June 2016.

1.3 The author of this paper is:
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2. Summary

2.1 The Living Well project is managed and delivered by the Council's CareLink Plus service. The project has an emphasis on early help and prevention by supporting people to maintain their independence and preventing the need for more intensive services in the future.

2.2 The project seeks to target and support people who are experiencing deterioration in health, have lower level social care needs or are struggling to cope with aspects of daily living.

2.3 The project started in June 2015 and this report provides an update on project activity and the outcomes it is providing for people. The project is funded by the better care fund and supports the Council's Value for Money (VfM) programme.

3. Decisions, recommendations and any options

This paper is presented to the Health and Wellbeing Board to consider:

3.1 The successes achieved since the start of the project show encouraging signs that this type of intervention can play an important role in the wider prevention agenda by supporting individuals and communities, as well as delivering cost-effective care. This report recommends that opportunities through the Better Care plan are explored to mainstream the Living well Project to enable more people to be supported.

4. Relevant information

4.1 The Living Well project forms part of the Brighton & Hove Better Care plan. There is £0.235 million funding in 2016/17.

4.2 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, encouraging people to do the things they enjoy, to get out and about and to live well.

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

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

4.4 The project supports the current strategic vision (Adult Social Care Services; The Direction of Travel 2016 – 2020) with an emphasis on signposting, supporting communities, getting people 'back on track' and helping people self manage their own care. Furthermore, the project supports strategic priorities of the Brighton & Hove Joint Health & Wellbeing Strategy 2015 to help people to age well and provide better outcomes for people by working in close partnership with NHS and community and voluntary sector colleagues.

4.5 The project starting taking referrals in August 2015 and has so far worked with 305 people. Key referrers include the Hospital Rapid Discharge Team, Hospital Social Work team, Integrated Primary Care Teams and the Access Point.

4.6 The person-centred approach to supporting people enables individuals to express areas of help that will make a difference to their lives and to support people to continue doing the things they like to do. This approach is highlighted in three stories in the appendix of this report which emphasise the human impact of the project interventions.

4.7 The project outcomes support the Council's VfM programme by providing early interventions for people which can help to reduce, prevent or delay the need for long-term care and support. By supporting people at an earlier stage and linking people with the right sources of support, it can help prevent small problems escalating, becoming larger and more difficult to manage.

4.8 It is accepted that the financial evaluation of preventative interventions such as Living Well are inherently hard to quantify. The project team has recognised, though, the importance of evaluation information and has developed a methodology to estimate where costs have been avoided through project interventions. This approach is based upon the professional evaluation of each case and the views of each person supported. It uses professional data sources to help quantify where care and support costs have been avoided. Since the start of the project, through this approach it is estimated that preventative savings of £1.565 million (after costs) have been achieved. Examples of this include where care home costs, home care provision or falls in the home have been avoided.

4.9 Whilst these figures are based on estimations, it is worth noting they are broadly consistent with other local telecare outcome studies. The study carried out by the Department of Health's Care

Services Efficiency Delivery (CSED) Programme in 2011 on Brighton & Hove telecare activity, and a similar exercise carried out by East Sussex County Council in 2014/15, showed preventative savings of between £5,000- £6,000 per person. This analysis provides an average figure per person which falls within this range, adding weight to the outcomes provided in this report.

4.10 One of the project's areas of focus is to build partnerships to support good integrated working. Strong partnerships and pathways can lead to more holistic and sustainable outcomes for people. The project has built strong links with NHS organisations, East Sussex Fire & Rescue and local community sector organisations such as Time to Talk befriending service and Crossroads respite care.

4.11 Feedback from partner organisations include;

"The ease of the referral and the fact that Living Well was able to see her the day she was discharged made the process quick and easy, and prevented a delayed discharge from hospital"
Emma Ball, Hospital Social Work Team

"It's been great for the fire service to work in partnership with CareLink Plus. We have seen a big rise in home safety visits and we are working together on a new hoarding framework. This is real action based partnership working to help make vulnerable people safer"
Mel King, East Sussex Fire & Rescue

"Without the support of the CareLink Plus team we quite simply wouldn't be able to successfully help individuals who are isolated, vulnerable and alone! Through a strong partnership approach to identifying need; assessing individuals; and providing joint provision, we have worked together to help older people living in the Brighton and Hove community who say their lives have been completely transformed for the better. "
Emily Kenward, Time to Talk Befriending

5. Important considerations and implications

5.1 Legal:

It is a function of the Health and Wellbeing Board to oversee and monitor provision of Adult Social Care in the City. The primary legislation governing Adult Social Care is the Care Act 2014. Section 2 of the Care Act 2014 imposes a duty on the Local

Authority to provide or arrange for the provision of services, facilities or resources, or take other steps, which it considers will—
(a)contribute towards preventing or delaying the development by adults in its area of needs for care and support;
(b)contribute towards preventing or delaying the development by carers in its area of needs for support;
(c)reduce the needs for care and support of adults in its area;.
(d)reduce the needs for support of carers in its area.

The Care Act also imposes duties to promote wellbeing, provide information and advice, work in co-operation and partnership with other organisations and meet care and support needs on a person centred basis.

Additionally in carrying out its functions the Local Authority must have regard to the Human Rights Act 1998; Article 8 of the European Convention on Human Rights provides for the individual's right to privacy and family life.

Lawyer consulted: Sandra O'Brien Date: 23/05/16

5.2 Finance:

The living well project is funded through the Better Care Programme in 2016/17 with a budget of £0.235 million. The project was within budget for 2015/16 and the expectation is the same for 2016/17.

The project provides early interventions for people, which can help to reduce, prevent or delay the need for long-term care and support. A review on clients that the project has worked with to date, estimate cost reductions (non cashable savings) in the region of £1.565 million (£5,000 per client). Examples of these savings are by mitigation of residential placements, night care and falls prevention.

Finance Officer consulted: Neil J Smith Date: 17/05/16

5.3 Equalities:

The project officers have received equalities related training and through their professional approach seek to provide good outcomes for all people supported, recognising and supporting specific equalities issues and needs. An equalities impact assessment will be completed on the project impacts.

5.4 Sustainability:

The preventive approach which this project provides supports the delivery of sustainable adult social care provision.

5.5 Health, social care, children's services and public health:

A partnership approach has been a key feature of this project to provide wide reaching outcomes for people. The project has been developed in conjunction with CCG colleagues and reports to the better care board.

6. Supporting documents and information

Appendix 1 Case study: Maisie's story
Appendix 2 Case study: Jean and Ron's story
Appendix 3 Case study: Jim's story

Please note, these case studies have been anonymised but are based on real-life situations.

Appendix 1

Maisie's story

Maisie is a retired nurse in her nineties, and lives by herself in Woodingdean, with a son living close by. She has a sharp sense of humour, a poor memory, and a history of falls. Community Short Term Services made contact with Living Well to request support around discharge planning to help Maisie to return home from inpatient rehab, following a best interest meeting. The understanding was that there would be a two week timeframe during which Maisie could still return to the short term service (nursing home) if discharge was not felt to be a success. While still at the nursing home, we were able to show Maisie a falls pendant, which would raise an alert for help if she were to have a fall, even if she didn't remember to press the button, and we discussed other equipment that could be a help to her. The decision following the meeting was that it was in Maisie's best interest to return home with support from a package of care and Telecare.

As Maisie returned home she was distressed and distraught as she didn't recognise her home environment. Just that week our team had become Dementia Friends, so we recognised straightaway that Maisie was expecting to see a home of her youth, and we encouraged her to recognise objects which may be familiar to her, like photos, cards, and ornaments, which would help to orient her to time and place.
Once Maisie was feeling a little more settled, we installed a bed sensor, smoke detector, carbon monoxide detector, a falls detector, and two flood detectors. Prior to Maisie's hospital admission she had tried to flush incontinence pads down the toilet which had caused flooding, and which had resulted in Maisie's landlord serving an eviction notice. Living Well were able to identify a suitable place for a temporary keysafe to be fitted until permission from the landlord was obtained for a permanent keysafe. This was crucial to the discharge going ahead that day and prevented re-admission to the nursing home.

The bed sensor and special falls pendant will support issues with night-time and day-time falls, alerting CareLink Plus if a fall occurs so help can be quickly accessed.

With the support of telecare alongside the home care calls, Maisie has been able to return home safely rather than move into longer term residential care. Maisie enjoys the social interaction with the carers, and looks forward to seeing her son.

Jean and Ron's story

Jean cares for her husband Ron who has advanced Alzheimer's Disease. With no package of care currently in place, Jean supports Ron with all activities of daily living. A recent assessment of Ron's needs confirmed that if he were to move into a residential placement he would need one to one support around the clock due to his high care needs and risks of falls.

At the point of referral to Living Well, Jean felt close to being unable to continue in her caring role. She was unable to attend her own health appointments, and had become low in mood – expressing suicidal thoughts and was unable to leave the house with Ron, as they were waiting for a wheelchair from the Wheelchair Service.

Through a referral to Living Well, a CareLink Plus unit was installed and a GPS device set up, giving Jean support at the touch of a button, in out of the home. She was referred to Crossroads, to allow her to attend her own appointments, and a referral was made to the Red Cross Equipment Loan service, through which Jean was able to rent a wheelchair. A Carers' Emergency Back-Up Plan was completed, and respite options were discussed. At the moment Jean and Ron are being supported to plan a holiday together at a Revitalise break, which will support Jean in her caring role, and give Jean and Ron some quality time together. A Playlist for Life is also being created, made up of Ron's favourite songs, which he will be able to listen to on an iPod.

Jean said the support from Living Well "has made such a difference to our lives. Installation of the CareLink unit and GPS has made me feel a lot safer. The Emergency Back-Up Plan means I don't worry so much about being ill, wondering how I would cope with caring for Ron whilst I was ill, because now I know I can call for back up. I am also so excited about the playlist for Life project. I know Ron will enjoy listening and singing along to his favourite music. I feel that the staff from Carelink are more like friends. They make time to listen, especially for people like me who are not always in contact with other people. I cannot thank you enough Charlotte, Carelink, Crossroads and all the staff who make life a lot easier."

Appendix 3

Jim's story

Jim is a fiercely independent 96 year old man who lives in Brighton. He has a history of recurring pneumonia, a heart bypass, severe hearing impairment, and he's awaiting a cataract operation.
Jim was admitted to hospital with community acquired pneumonia, and was referred to Living Well by the Hospital Social Work Team to support him to return home. We were able to visit Jim on the same day we received the referral, and made a visit at the same time as Community Rapid Response Service (CRRS) who were also supporting Jim to return home safely. In addition to installing the CareLink unit and alarm pendant so Jim could call for help in an emergency, we identified that Jim would benefit from a smoke detector and carbon monoxide detector as there was a note on Care First reporting a small house fire in 2013. For the moment Jim has declined these but we are hoping that he will accept these.

A week after the CareLink unit and pendant had been installed Jim pressed his button and reported shortness of breath, and was able to be admitted to hospital in an appropriately timely way, and receive treatment as soon as possible. After returning home for a second time, Jim reported being very cold at home, and we contacted the Red Cross Discharge service who were able to provide extra blankets and a warm pack straightaway. The Red Cross also got in touch with Jim's GP, who was able to confirm an appointment for his cataracts, which is hoped will improve his eyesight and reduce the discomfort he has been experiencing.

At this time, Jim said he would like to move, as his bedsit flat has one small fire which he sits in front of to keep warm, there is a communal toilet and shower at the end of the corridor down one step, and this involves walking in the dark to get to the light switch. A urine bottle has been ordered to reduce the risk of falls at night, and an application to Homemove is going to be completed to support Jim to move into more appropriate accommodation.

We have also been able to refer to initial Response Service Technicians (IRST) to trial hearing equipment for his door bell, phone and the TV, which will help Jim to hear when he has visitors and phone calls, as well as ensure he can enjoy the programmes he likes to watch. Jim receives a daily meal from Coleman's Meals, he continues to be able to get out and about, and is independently completing activities of daily living.