Updated July 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Brighton and Hove City Council**
Clinical Commissioning Groups	**Brighton and Hove Clinical Commissioning Group**
Boundary Differences	**The City Council and CCG boundaries are coterminous**
Date agreed at Health and Well-Being Board:	**09/09/2014**
Date submitted:	**16/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£5,631**
2015/16	**£18,065**
Total agreed value of pooled budget: 2014/15	**£7,632**
2015/16	**£19,660**

b) Authorisation and signoff

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

Signed on behalf of the Council	Brighton and Hove City Council
By	Catherine Vaughan
Position	Executive Director of Finance & Resources
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Brighton and Hove Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Jason Kitcat
Date	<date>

c) Related documentation

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

Document or information title	Links
Better Care Fund Project Initiation Document Outlines the programme management approach to the Better Care Plan, the associated projects, dependencies and governance arrangements.	Project initiation Document FINAL.pd
Capita Report – Frailty Model Development • Defines frailty for Brighton & Hove's community as a group who will benefit from an integrated approach to care in the city • Identifies the financial cost of services for the frail population • Maps existing services using a range of data such as activity, performance, finance quality and outcomes • Identifies what is working well in the current system, what needs improving and where there are gaps • Benchmarks Brighton and Hove against comparators • Assesses the current provider landscape • Identifies opportunities to release funding in line with the strategic drive towards community care and away from the acute sector	BH Frailty Final Report Draft v0 3 2
Service Map A map which shows graphically the range of community health and social care services currently available in Brighton and Hove.	Frailty map.pptx
Homeless Integrated Pioneer Bid 2013 A bid was submitted to be one of the Integrated Pioneer site to develop an integrated model of care for the homeless. Although we were not selected as one of the Pioneer sites, the implementation of the model is one of the key work programmes that will form part of the Better Care Fund. The evidence for this	Homeless Integrate Care bid 2013

approach is contained in the attached document.	
Adult Social Care City Summit Event 11 June 2013 "Have Your Say" Summary Report Detailing Stakeholder Feedback from the Adult Social Care City Summit Event to discuss the future of Adult Social Care.	City Summit report - June 2013.pdf
Integrated Primary Care Team Service Specification Integrated Primary Care Teams are multi-disciplinary teams that provide pro-active care to people with long term conditions and/or who are frail. The focus of teams is to keep people well at home and avoid emergency admissions to hospital.	IPCT service spec March 2014
Joint Health and Wellbeing Board Strategy Outlines the key health and wellbeing challenges that face Brighton and Hove and our approach to tackling these issues.	Joint Health and Wellbeing Strategy
Report from Phase 1 Frailty Workshop – 21 July The workshop was held as part of the work programme of the Better Care: Integrated Frailty Board. The overarching remit of the Frailty Board is to scope the vision in more detail and oversee the implementation of a more integrated model of care. The overarching aims of the event were threefold: • To share the high level vision; • Provide an opportunity to shape how phase 1 can be developed; and • Provide an opportunity to get to know each other better.	Frailty workshop feedback and repor Frailty workshop action plan
Report from Homeless Workshop – 11 July	BH Homeless Integrated Health a
Brighton and Hove Joint Strategic Needs Assessment http://www.bhconnected.org.uk/sites/bhconnected/files/jsna2013.pdf	
Proactive Care Specification Specification for primary care delivery of proactive care for frail and vulnerable people in Brighton and Hove.	Proactive Care for Frail and Vulnerable
Scheme Description Scheme outlines for Annex 1	BCF Outline template - Master 04Sep2014 -
Programme Plan High level programme plan for delivery of the integrated care model and enabling workstreams	Better Care Programme Plan incl

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Background

There is a long and successful history of partnership working in Brighton & Hove, with formally shared council/NHS services; close informal partnerships between the council and the NHS; and a thriving strategic partnership structure, with the council, NHS commissioners and providers, city universities, the police, the fire service, voluntary sector organisations and local businesses working together across a variety of themed partnerships.

Over the past few years Brighton and Hove CCG and Brighton & Hove City Council Adult Social Care Directorate have made substantial investment in health and care services with the aim of keeping people healthy & well, providing services that promote independence, delivering proactive care at home, and facilitating discharges from hospital. We have some excellent examples of integration, for example multidisciplinary hospital discharge teams, community short term services, mental health and dementia services and multi-disciplinary, multi-agency, integrated primary care teams (including dedicated Carer Support Workers). However, at a system level we know that our services are fragmented and do not always address the holistic needs of an individual.

Previous mapping and consultation work has also identified that the system is not well set up for individuals who have multiple or complex needs. We also know that where people have complex needs, the care they receive is often fragmented and not joined up. Not all community services are available 24 hour a day 7 days a week and in addition the complex web of services mean that it is not always clear which service or organisation should be accessed. We know this sometimes means that people attend A&E and are admitted to hospital as these are services people are familiar with and are generally known to be available 24/7. However these services do not always provide the best outcomes for people in that they can often reduce rather than increase independence.

The Brighton and Hove Better Care Plan describes how we will deliver improved services for our frail and vulnerable population to help them stay healthy and well by providing more pro-active preventative services that promote independence and enable people to fulfil their potential. The Plan draws on a wide range of experience and evidence of best practice both locally and nationally and includes the views of people, their families and carers, members of public and local stakeholders.

National Drivers & Context

There are a range of issues affecting health and social care nationally that have driven the need for a different approach to the delivery of care: These include:

- Rising demand due to both a growing & ageing population and an increasing number of people with complex multiple health care needs and new treatments available that are able to preserve life
- Funding for health services not rising in line with demographic demand and significant reductions in social care funding.
- Current feedback is that whilst individual services are good there are gaps in service

provision, as well as gaps in terms of communication between care settings

Local Drivers and Context

Many of these national issues are relevant to Brighton and Hove. Brighton and Hove is a small City by the sea with a population of 273,000[1]. The City is a popular place to live and our population is predicted to increase to 291,000 by 2030.

Brighton and Hove has distinctive demographics. Compared with England as a whole, we have:

- A lower proportion of children,
- A much higher proportion of people aged 16-64 years;
- A lower proportion of people aged 65-74; and
- Similar proportion of people aged over 85

We face many of the same national issues but we do have some differences due to our demographics. Some of the key health and wellbeing issues[2] that have informed our vision for integrated care are:

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

[1] ONS mid -year population estimates for Brighton and Hove 2011

[2] Identified by the 2013 Brighton and Hove Joint Strategic Needs Assessment

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.

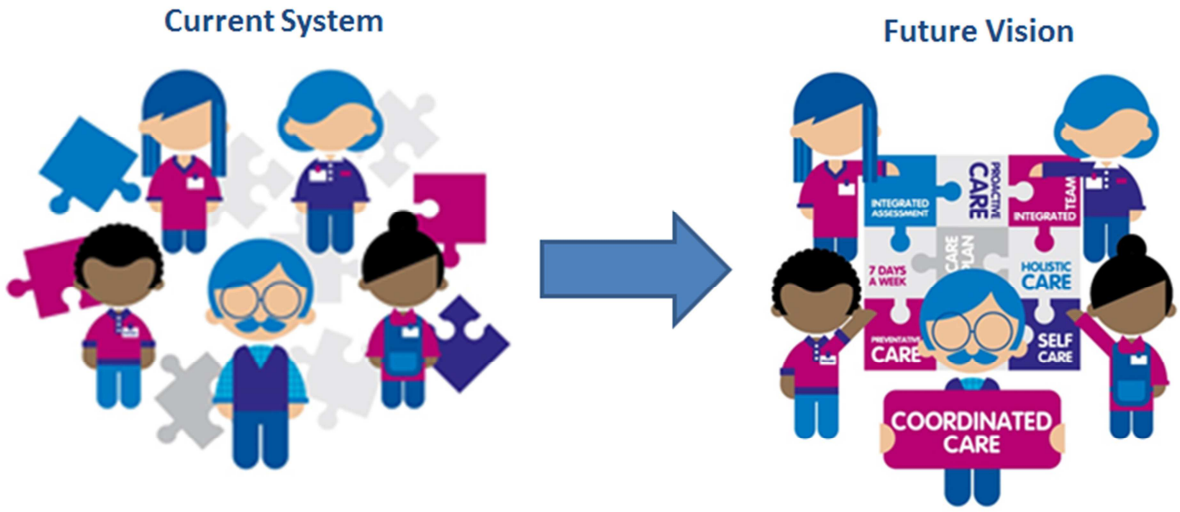
Our Vision for Better Care

Our vision for our frail 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. This includes senior decision making at the `front door` of the hospital (A&E), improved communications within and between the hospital team and community teams, a clear, inpatient care plan that the person is involved with, on-going rehabilitation and reablement in hospital, and swift discharge planning arrangements the community team via a single, shared assessment for discharge.

We are working together as a whole system to improve patient flows out of acute hospital settings to ensure that people can move out of hospital in a timely way when they no longer needed acute care, facilitating independence and reducing unnecessary lengths of stay in hospital. We plan to test out a “discharge to assess” model that will assess people in a home environment rather than a hospital environment. We plan to focus on frail peoples and anticipate this new way of working impacting in terms of reducing length of stay in hospital and delayed transfers of care as well as longer term reducing the need for packages of care.

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. The current state and the future state is shown graphically below.



Our approach to integration is based on the following principles:

- We will learn from our local experience of integration
- We will continue to strengthen our existing services building on things that have been shown to work.
- We will streamline the care pathway minimising duplication and barriers between services.
- We will test out our plans for integrated teams before implementation across the whole City

- Our plans will be developed and implemented by those with lived experience of care (people and their carers) as well as front line staff delivering care.
- We will support this through a programme of organisational development

Programme Objectives and Cross Cutting Themes

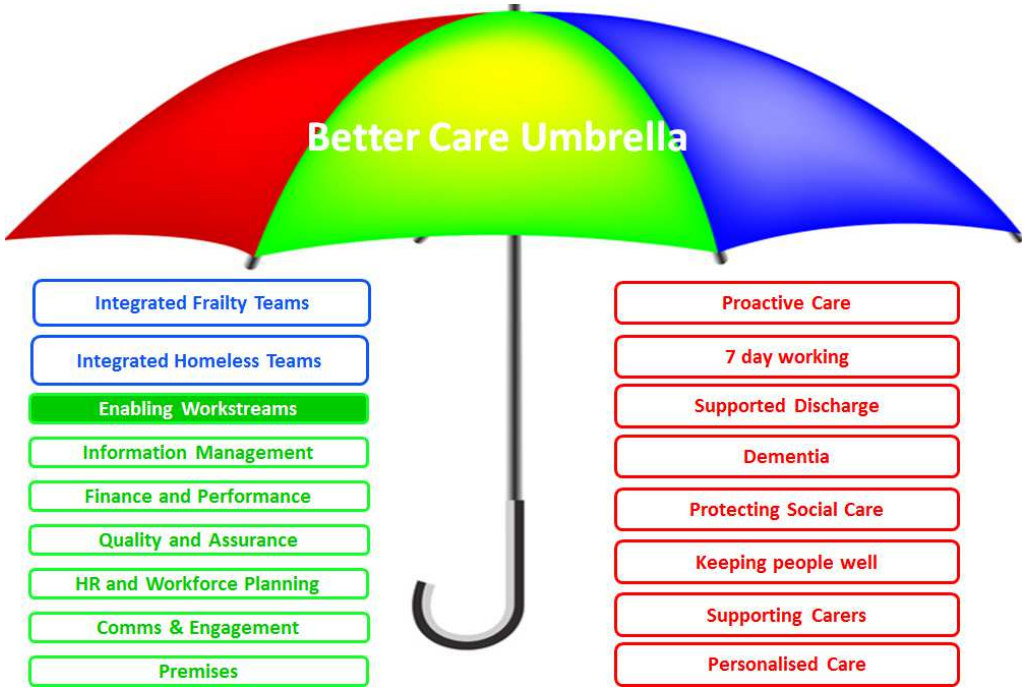
The following objectives underpin our Better Care programme of work:

- Person Centred – designed around the individual and delivered close to home
- Proactive and Preventative – helping people stay healthy and remain independent,
- Responsive and co-ordinated – available when needed (whatever the day of the week) and provided in a seamless and co-ordinated way thereby minimising admissions to hospital
- Support Recovery and maximise independence - when someone is admitted to hospital the system will support them to recover and return home as soon as they are ready
- Truly Integrated – organisations working together in innovative ways to provide integrated health and social care services

Scope

The unique demography of Brighton and Hove has lead us to believe that a focus on people who are frail alone will not deliver the sort of health improvements needed for our most vulnerable communities nor have the necessary impact on statutory service provision. For this reason we are working to a broader definition of frailty and incorporating those with complex care needs or a vulnerability to adverse health outcomes, whatever their age. We estimate that approximately 5% of our adult population will be defined as significantly frail and a further 10% of our over 65 year old population with moderate frailty.

The Better Care Programme encompasses a number of new and existing projects; collectively they deliver the Better Care vision. The projects which come under the 'umbrella' of Better Care are illustrated below and summarised in the following sections:



Better Care Projects

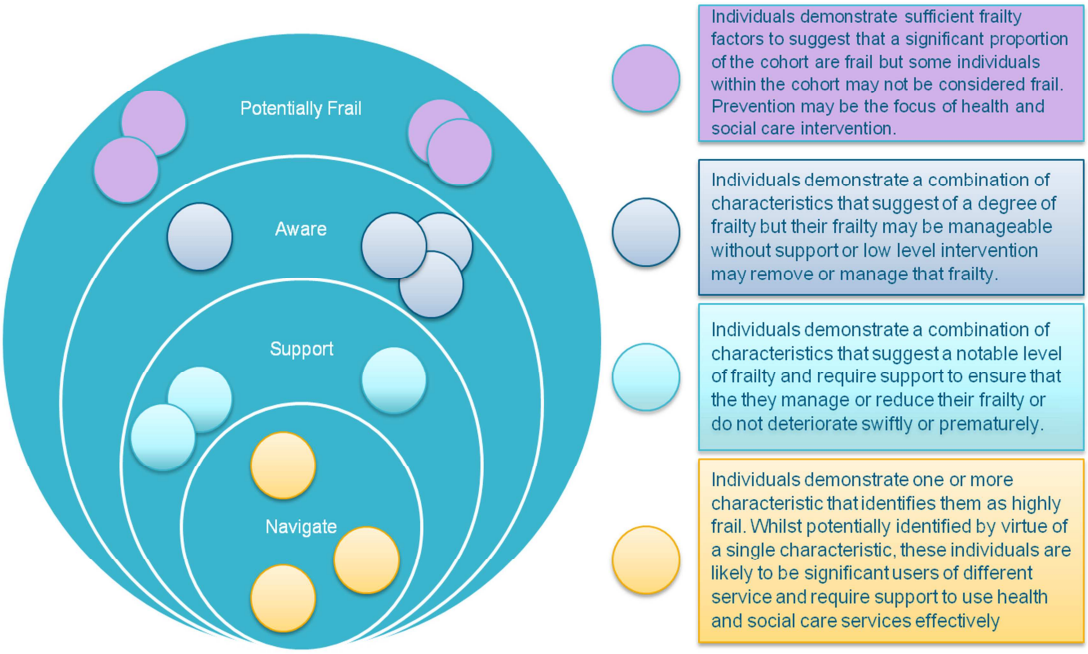
Co-ordinated and integrated services for people with long term conditions have potential to deliver better and more cost-effective care if they are well designed, involve professionally trained case managers and care teams, and are embedded in a wider system that supports co-ordinated care (Ross et al 2011).

Listed below are the projects which are stepping stones in delivery of the better care model. They enable us to prepare services, i.e. by ensuring 7 day working, test out new models, i.e. proactive care, and to collect information about our frail and vulnerable population to inform the shape and structure of the future integrated services.

Integrated Frailty Model

In 2014-15 we will test out the development of integrated multi-disciplinary teams based around two clusters of GP practices. The teams will include staff from community services, mental health and substance misuse, social care, carers, independent sector providers as well as the community and voluntary sector providers.

We have defined a frailty framework for Brighton and Hove based on 4 levels of frailty:



We will deliver more integrated and holistic care for all levels of frailty, starting with the cohort of people with the most complex care needs. We will build on our Integrated Primary Care Teams (a model that started in 2012 based on the Chronic Care Management Model) be more embedded with Practice staff and extend their scope to cover all frail people registered at those practices (not just house-bound people requiring input).

- Potentially frail (prevention and proactive support to prevent frailty in the longer term, this will include self-management);
- Awareness of frailty (low level intervention, a mix of health, social care and voluntary sector, this will include self-management);
- Support (formal support from a combination of health, social care and voluntary sector, keeping a watchful eye to ensure they do not deteriorate and require more intense care, this will also include self-management and a clear, agreed and shared care plan that is regularly reviewed); and

- Navigate/ care coordination (the individuals requiring intense support to ensure they are supported within their own home as long as possible, using an integrated support plan

We will increase the capacity and skill mix within the integrated teams and extend the membership of the multidisciplinary team to consistently incorporate mental health/substance misuse and social care staff and facilitate a more formal involvement of carers, independent care providers and the community & voluntary sector in the partnership. We will strengthen line management and governance structures within the integrated teams and stronger links to teams in the council will be developed for example housing, public health, and communities team, to make sure people receive a suitable response, and to make the best use of the skills and resource in local areas.

We will test out this integrated MDT model in 2014-15 around two cluster of GP practices The first cluster consists of three practices in Hove (Wish Park Surgery, Sackville Road Surgery and Central Hove Surgery serving a population size of 22,000) and St Peters Medical Centre and Park Crescent Surgery serving a population of 24,000) . We are testing out the integrated MDT model at a relatively small scale at first to ensure lessons learned inform the full roll out across the whole city in 2016/17.

We will reshape the model of care by bringing relevant staff out from the acute setting and embed them in the community team so that their remit is to in-reach to hospital when people require an acute stay and to support their discharge with a shared single assessment discharge plan.

These integrated MDT's based around clusters of GP Practices will have rapid access to specialist support when required and their entry into step up and step down support from hospital will be streamlined.

Each frail person will have a designated "care co-ordinator" drawn from the integrated MDT who will navigate and support the individual as necessary. Depending on the specific needs of the frail person the care co-ordinator could be from any profession within the MDT – including the independent, community & voluntary sector and/or carer and will take responsibility for active co-ordination of care for the full range of support (from lifestyle support to acute care);

Care will be co-ordinated in a single place to ensure service users and carers only need to tell their story once. This will be supported by electronic sharing of data with all involved in providing care, and the development of a single care plan that is reviewed, updated and shared appropriately;

Integrating care for homeless people

Given the Brighton and Hove demographics the profile of our frail and vulnerable population is not exclusively linked to older age and we have identified homelessness as a key element of our Better Care Plans. We have established a Homeless Board to provide sufficient strategic focus to this part of our Plans. Conceptually we will be using a similar MDT approach focused around primary care and embedding community services, mental health and substance misuse, social care, carers, independent sector providers as well as the community and voluntary sector providers. The model developed will be bespoke to the community's needs and include for example greater use of out-reach models of care, investment in supported step down services from hospital and greater support on housing related issues. We will test and evaluate this approach concurrently with the frailty model described above.

We will embed evidence based practice and personalisation in all areas of service delivery

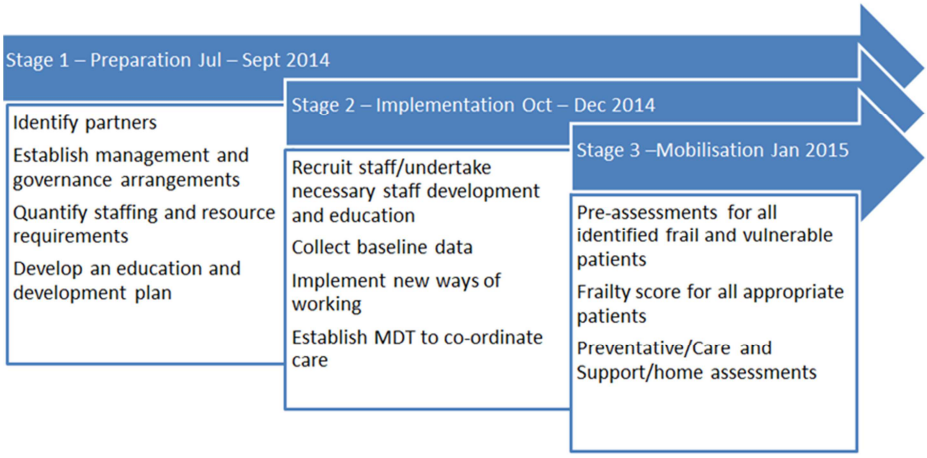
sharing the learning locally and nationally. The overarching impact on quality will be increased registration with a dentist (from 38%), improved access to mainstream community health and social care services, and client experiences. Clients report high levels of both physical health (84%) and mental health (85%) needs many feeling these needs were not being met and left needing more support.

Proactive Care

Proactive Care is a model of care based on national and international evidence of best practice, which ultimately aims to achieve whole system health and social care integration, in order to support and deliver better outcomes. We have already established Integrated Primary Care Teams (IPCT's) and we will continue to build on this model. GP's will play a significant role in supporting the coordination of care for the frail and vulnerable. In 2014/15 we use of the £5 per head of registered population funding (equivalent to £1.5m for the City) to roll out a Locally Commissioned Service (LCS) for people with complex health and care needs in order to support GPs deliver their role as the profession responsible for co-ordinating care around our frail population and to compliment the new Proactive Care Directed Enhanced Service.

To complement the development of the locally commissioned service (LCS) we will strengthen a range of existing community services with the aim of keeping people well at home and being able to respond rapidly in a crisis and avoiding admission to hospital.

This LCS will operate for a nine month period from 1 July 2014 until 31 March 2015. During this period the CCG will work with practices to develop an agreed approach to risk stratification, frailty assessment, care planning and case management. At the end of the period a system wide evaluation will take place joining up the learning from frailty phase 1, proactive primary care and EPIC. This will inform the full integrated model due to be mobilised in 2016/17:



Personalised Care

Case management exists in many different forms, but it is generally described as 'a targeted community-based and proactive approach to care that involves case-finding, assessment, care planning and care co-ordination' (Ross et al 2011).

Underpinning effective case management and co-ordination is a consistent process for assessment and care planning. Services need to have a shared understanding and access to a single record to ensure that people do not have to repeat their story.

During 14/15 we will design and test a model of comprehensive assessment and care planning. We will bring together a wide range of views from clinicians, health care professionals, individuals

and their carers to develop a standard assessment and care plan. With the support of the IM&T workstream we will develop a secure electronic method of shared access across the system. The model will be tested by primary care though the proactive primary care project, with community and MDTs via the phase 1 roll out and will align to recognised secondary care standards. Evaluation will take place as part of the wider system evaluation in April 2015.

Personal Health Budgets are a key aspect of personalisation - with the aim of improving outcomes by placing individuals at the centre of decisions about their care. By working alongside health service professionals to develop a care plan, and through taking ownership of a known budget, individuals will achieve greater choice and control of the services required to support their needs. The PHB project is integral to the CCG vision for the local frail population by actively promoting individual's ability to stay healthy and well by providing 'whole person care', promoting independence and enabling people to fulfil their potential. During 14-15 the project will concentrate on delivering the national requirements that from October 14 all adults and children eligible for NHS Continuing Healthcare will have a right to have a personal health budget, and establishing arrangements for children with complex needs to access PHBs. For 15/16 the focus will be on maintaining arrangements for continuing healthcare/complex children, and further extending the PHB offer to small cohorts of individuals with long term conditions through the Better Care Frailty Phase 1 programme. The CCG, Brighton & Hove City Council and voluntary sector may also wish to participate in the national Integrated Personalised Commissioning programme.

Investing in services to provide more consistent 7 day a week working

We will build on our 7 day working by investing in a range of service developments including:

- 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;
- increase availability of night sitting 7 days a week,
- increase capacity in our 7 day a week Community Rapid Response Team (available to respond to emergencies within the community and facilitate timely discharge).
- work with the acute trust to ensure consistent 7 day working within the hospital and enable timely discharge across the entire week.
- build on our hospital and community social work service and on the infrastructure to support out of hours services.
- work with care home & home care providers to ensure a timely 7 day response to requests for services
- Strengthen our seven day crisis response for mental health

In addition to this we will undertake a mapping exercise to understand which services are currently 7 days and which need to be. This programme of work cuts across a number of delivery areas however co-ordination and oversight will be the responsibility of a lead individual to ensure that the whole system is aligned and prepared for the roll of out of the new model of care in 2016/17.

Supported Discharge

This programme of work aims to reduce unnecessarily long stays in hospital by providing the

support package and resources to ensure a quicker and easier discharge. We will strengthen discharge planning across the whole system starting at the front door of A&E with continued funding for the Hospital Rapid Discharge Team and review and extend the Hospital Liaison post responsible for discussing discharge arrangement with individuals and their families at the earliest stage. We will work with BSUH to increase the numbers of discharges at weekends and streamline processes for rapid assessment and discharge of individuals requiring complex care packages or short term services. We are planning to test out the development of a Discharge to Assess Model of Care to improve the flow in the hospital and reduce delayed transfers of care.

Better identification of people with dementia

We anticipate one of the key groups of people that will benefit from the new MDT approach outlined will be people with dementia and their carers'. Only 51% of residents in the City that have dementia have a formal diagnosis. Lack of diagnosis limits access to the relevant care and support and increasing diagnosis rates is a key element of our Better Care Plan. The current system of care (which largely separates physical and mental health care) does not provide the optimal model for managing care holistically. We know from audits of acute sector activity that people with dementia are much more likely to be admitted to hospital than people without dementia and the reason for admission is related to their physical health issue (for example a Urinary Tract Infection) rather than related to their dementia. We also know that length of stay for people with dementia is longer than for people without. The new holistic model of MDT care that manages dementia and other long terms conditions will bring significant benefits in terms of the ability to provide care closer to home and reducing hospital admissions. Prior to the full City roll out of the MDT's we will invest in additional capacity within our memory assessment service, support a programme of audit work General Practice with the aim of increasing our identification rate to 67% by 31 March 2015. We will also continue to strengthen our support to people with dementia.

A focus on supporting Carers

We will further strengthen our dedicated specialist services for carers. Brighton and Hove has a strong track record in developing responsive services to support carers, both within the statutory and voluntary sector. We will build on our dedicated support for carers and ensure they are central to the development of services within the City. For the past two years we have been piloting a pioneering approach to supporting carers through greater integrated working. We have dedicated Carer Support Workers based within each of the locality based Integrated Primary Care Teams. This role has enabled three key strategic outcomes to be progressed:

- a named worker for identified carers to provide a range of responses (including carers assessments);
- greater awareness of the needs of carers within the Integrated Primary Care Teams (IPCTs) and General Practice's (GPs); and
- Better awareness of the range of carers' services available.

This model is proving to be very successful, with high levels of satisfaction from carers, increasing recognition of carers, and greater access to dedicated services. We will strengthen the proactive role of carer support within our frailty model of care and launch a number of city wide initiatives aimed at increasing awareness of the needs of carers and support on offer.

Protecting Social Care

All of the funding currently allocated in 2013-14 under the Social Care to Benefit Health Grant

has been maintained to enable Brighton and Hove City Council to maintain the current eligibility criteria. Whilst the local eligibility criteria will not change, 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.

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

By pro-actively supporting people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own care wherever possible in their own homes this enables a better use of overall resource. Continued investment in Telecare and Telehealth for a wide range of people as a cost effective way of meeting an individual's outcomes and person centred planning support goals;

Keeping People Well

The recent Commissioning Prospectus (aimed at community & voluntary sector organisations) had a range of outcomes to ensure that service providers in the community & voluntary sector positively promote healthier behaviours and lifestyles. Adult Social Care, Public Health and the CCG worked with providers across the city to support people to make and maintain positive lifestyle behaviour changes by either offering healthy lifestyle information or signposting as appropriate.

The outcomes identified in the Commissioning Prospectus (2013) for older people's activities were:

- Supporting people to be as independent as possible;
- Reducing social isolation; and
- People remain healthy & well for as long as possible.

From April 2014 older people community and voluntary social activities have been commissioned in locality or activity hub areas across the city. There are three activity hubs – east, west and north central. Each activity hub will have a mix of services that include community based groups, befriending services and building based day services.

In addition to the work in local areas there are a number of initiatives that will support the focus on preventive services:

- Work with the community & voluntary sector to proactively support them to attract and alternative funding opportunities (e.g. Brighton and Hove are through to the second round of the Big Lottery Ageing Better bid);
- Increased support for carers through jointly commissioned support services, better information for carers, greater identification within community services and increasing carers assessments;
- Development of better information signposting & advice services;
- Continued emphasis on personalisation and supporting people to manage their own care;
- Continued investment in Telecare and Telehealth for a wide range of people as a cost effective way of meeting an individual's outcomes and person centred planning support goals;
- Capacity planning with home care and nursing home providers; and

- Home care providers will be encouraged to take a more significant role in identifying solutions to support service users in achieving their outcomes: innovative practice will be important in helping people achieve their goals.

b) What difference will this make to patient and service user outcomes?

Case Studies

The impact that we expect our plans to have on people are outlined in two case studies -one focused on frailty and the other on homeless.

Rachel - a 64 year old woman living in extra care housing

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

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

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

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

- I am supported in a timely way when my needs change: The Care Co-ordinator will pro-actively ensure that services are in place that can be flexible to respond swiftly to Rachel's changing (e.g. if she has a fall). The responsive service will be available 7 days a week. If Rachel does need to go to hospital and be admitted for suitable treatment, the hospital will be aware of the community services supporting her, aware of her care plan, and who to coordinate her care with. While in hospital, Rachel will continue to be encouraged to self-manage where possible, her rehabilitation and reablement will be proactive and the system will support her discharge when the time is right (even if this is at a weekend) so that she is not delayed in returning home with the support required. With the right level of proactive rehabilitation and reablement we will prevent Rachel from requiring long term on-going care including residential care.

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

The second case study is Dave's story which was discussed at a Homeless workshop on 11 July 2014

Dave – Now

Dave is a 40 year old man with drug and alcohol issues, he has been living in Brighton for the past three and a half years. During this time he initially sofa surfed with friends but most of these friendships broke down and Dave ended up homeless and rough sleeping.
He has been in and out of several homeless hostels.

During the past 18 months his alcohol and substance misuse has steadily increased, he disengages from services during periods of heavy drinking. He says he drinks to manage the pain he has as a result of previous falls. When under the influence he frequently exhibits anti-social/aggressive behaviour. He often presents as being in low mood, he has talked about not being able to go on with things the way they are. He spends much of his time on the street, drinking with members of the street community or begging.

Dave is known to agencies and has had some engagement with a number of them though this has not been sustained. He is registered with a GP but has not managed to get to any of the appointments made for him. He often presents as unwell in the evening, when he is most heavily intoxicated.

He very often ends up at A&E, either when he falls over, or has fits when street drinking. Sometimes hostel staff need to contact emergency services in the evening when he is very unwell. He's recently been in hospital for 4 days with suspected head injury, but discharged himself as soon as he was able to walk about.

Dave – The Future

Dave's health and care needs will be better met as a result of person-centred, and integrated assessment and care planning.

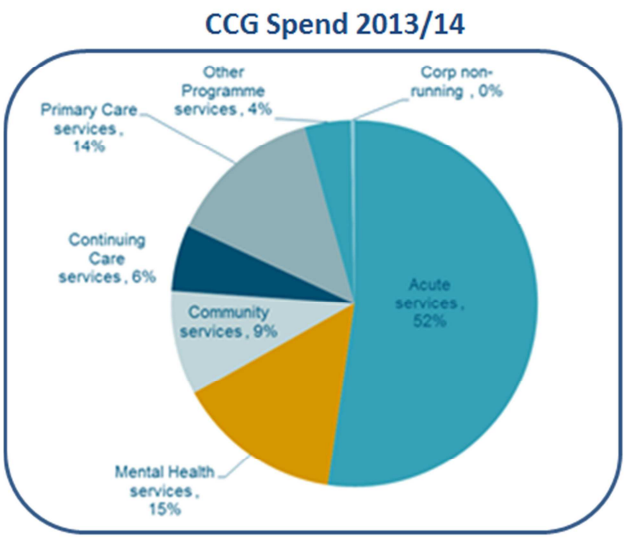
- Dave's individual health and care needs will be **comprehensively assessed** by the specialist MDT taking into account and building on his personal strengths.
- A **holistic care plan will be co- produced** and shared with Dave. Opportunities for care to be purchased via a **personal health and care budget** will be explored within the care planning process
- A **care co-ordinator** will ensure that Dave's care is co-ordinated and streamlined and that Dave is supported within this process remains well informed and **in control of his care**.
- Dave will find it easier to access support due to the **increased responsiveness and flexibility of services** in terms of where services will be delivered such as greater in reach to hostels and the increased hours services will be available.
- With **greater integration and clear agreed pathways** between services, any barriers to access will be reduced. Services will recognise the windows of opportunity in Dave's journey and will respond quickly to encourage and **maintain Dave's' engagement** with the appropriate treatment and support, and will **reduce Dave's reliance on unplanned and emergency services**.

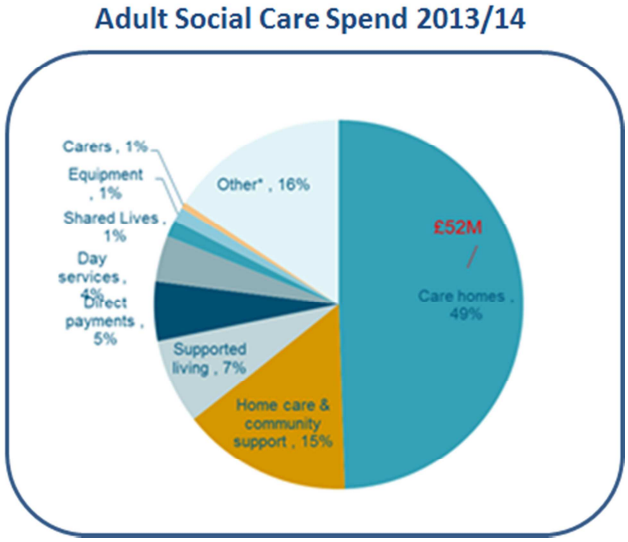
c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Current Configuration

Across Brighton and Hove approximately £420m is spend on health and social care services.

- CCG - £316 million per year – just under half of which is spend on acute services
- Adult Social Care - £105 million per year – half or which is spent on care homes





The provision of health care is dominated by three major NHS Trusts:
- 84% of acute care is provided by Brighton and Sussex University Hospital Trust
- Most community services are provided by Sussex Community NHS Trust
- Most mental health services are provided by Sussex Partnership NHS Trust

67% of the Adult Social Care budget is spent on care & support services in the independent, community & voluntary sector, with the remaining 33% being spend on services that are directly provided by the council.

The current system structure means that wide ranging change can be achieved by working with a relatively small number of providers.

The current system is characterised by a range of a range of organisational silos with pockets of service integration, for example mental health services are integrated across health and social care and community short terms services are delivered in an integrated way (see service map attached)

Future Configuration

The greatest proportion of local spend is on acute and long term care. Through our Better Care plans we aim to reduce expenditures in these sectors and move this resource to the community to deliver care in an integrated way.

The exact delivery vehicle for our integrated care model has not yet been agreed but we will expect to see all local providers of care working together to deliver integrated care based around clusters of practices where it makes sense to do so supported by “community hubs” of specialist care where economies of scales are required.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Defining Our Approach to Integration

Our approach to integration is driven by the needs of our population and our unique demographics (outlined in Section 2 of the Plan). We are aware that that integrated models implemented elsewhere will not fully meet our needs. During April 2014 we undertook a detailed piece of analysis to help us:

- Define frailty for Brighton & Hove's community as a group who will benefit from an integrated approach to care in the city
- Identify the financial cost of services for the frail population
- Map existing services using a range of data such as activity, performance, finance quality and outcomes
- Identify what is working well in the current system, what needs improving and where there are gaps
- Benchmark Brighton and Hove against comparators
- Assess the current provider landscape
- Identify opportunities to release funding in line with the strategic drive towards community care and away from the acute sector

A compendium of the analysis findings is attached at the beginning of this plan and summarised below.

Defining Frailty

As part of our analysis work we developed a frailty framework (outlined in Section 2) to ensure our plans target cohorts of people where there is most opportunity to improve quality of care and reduce avoidable and unplanned costs. The frailty framework has two key concepts:

1) A variety of factors contribute to a person's frailty. These included mental health issues, homelessness, substance misuse.
2) There are differing levels of frailty that require different levels of support

Our Frailty Framework therefore consists of both:

- The nature of frailty
- Level of frailty

In practical terms frail people can be defined by:

- Characteristics or conditions they exhibit
- Behaviours that they exhibit
- The services that they use.

The framework identifies types of population who may have reached a crisis which has resulted in unplanned or un-co-ordinated care. The framework enables us to target the particular cohorts

where there are opportunities to provide more pro-active support and avoid or mitigate the impact of any crisis.
In some cases a single characteristic or behaviour or the use of a specific service suggests that in all probability an individual is frail. For example there are unlikely to be individuals residing in residential or nursing care who are not frail. However, there are also factors that whilst they may make someone frail that factor alone does not define the individual as frail. For example someone with dementia may be frail but equally they could be in the early stages, managing well and being supported by friends and family and fall outside of a definition of frailty.

Some factors whilst important have been excluded as single identifiers of frailty as some individuals within these groups are not frail in terms of their capacity to deal with crisis or issues of daily living.

Single Factor
Recipients of Social Care Funded **Home Care**
Social Care funded residents in **Residential Care**
Social Care funded residents in **Nursing Care**
Recipients of **Continuing Health Care**
People currently receiving services from the **IPCT**
Mental Health service users on **CPA**
Individual in receipt of on End of Life programmes

The framework identifies a long (although not exhaustive) list of characteristics that in combination contribute to an individual being identified as being frail. Firstly we have identified a number of key factors. These are characteristics that have a high likelihood of generating frailty although which alone are not sufficient. Each of these is then cross referenced with one or two other cross-referencing factors:

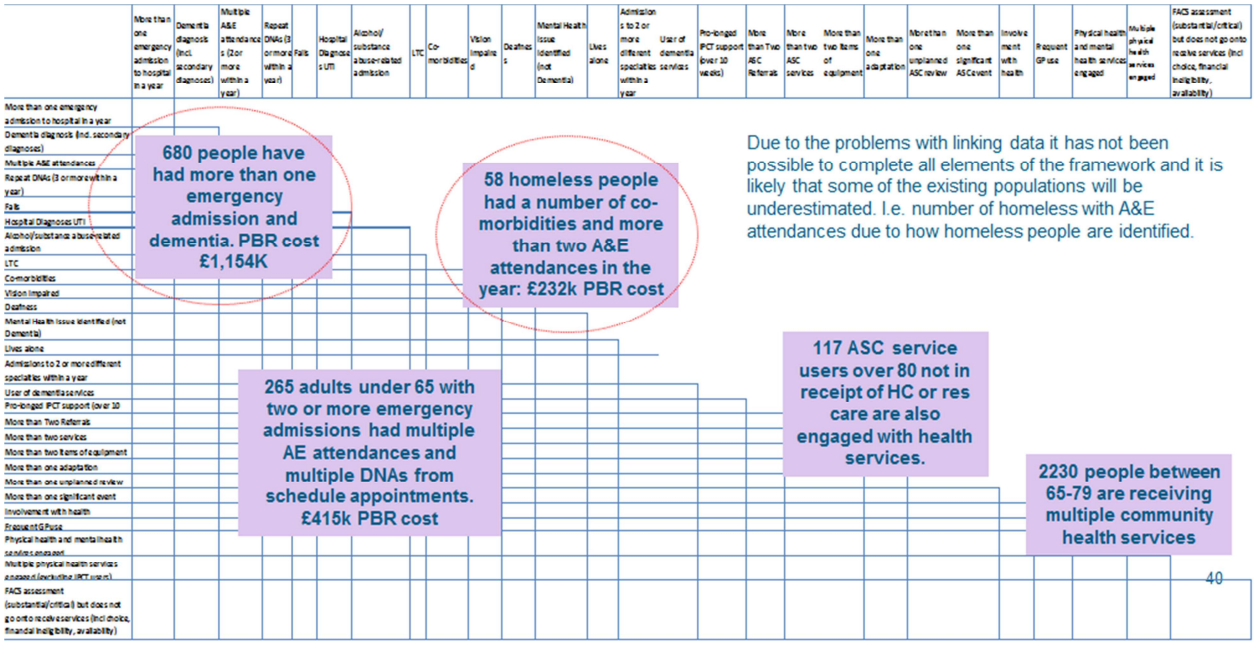
Key Factors
Homelessness
Aged over 80
Having a learning disability
Under 65 but with more than two emergency hospital admissions
Aged between 65 and 85 (requires two additional factors not one)

These cross-referencing factors have been developed from discussion with the programme leads and review of research on contributing factors of frailty. Some of the factors may have a greater weighting in terms of indicating frailty. The relevance of some of the factors may also vary depending on the models of care that are planned to be introduced.

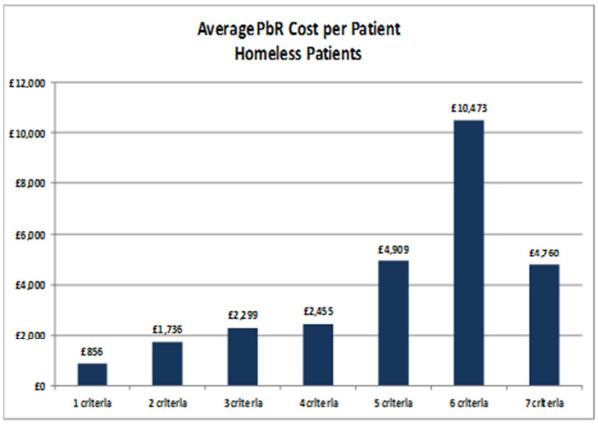
Analysis of the impact of the number of cross-reference factors show that complexity and costs of supporting individuals increases as the number of factors increases.

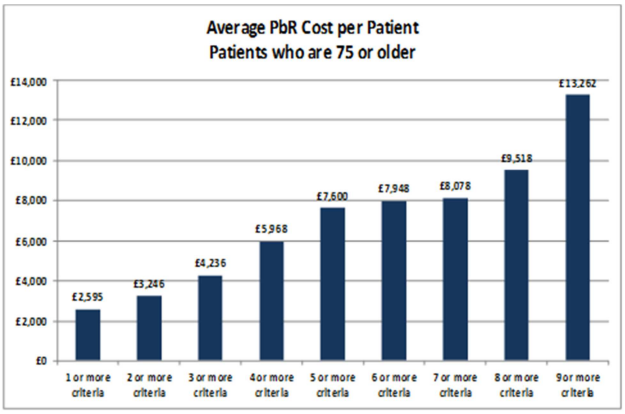
Cross Referencing Factors
More than one emergency admission to hospital in a year
Dementia diagnosis (incl. secondary diagnoses)
Multiple A&E attendances
Repeat DNAs (3 or more within a year)
Alcohol/substance abuse-related admission
Long Term Conditions
Co-morbidities
Vision Impaired
Deafness
Mental Health Issue Identified (not Dementia)
Lives alone
Admissions to 2 or more different specialties within a year
User of dementia services
Pro-longed IPCT support (over 10 weeks)
Frequent GP use
Physical health and mental health services engaged
Multiple physical health services engaged (excluding IPCT services
FACS assessment (substantial/critical) but does not go onto receive services

The outcome of the approach taken is a series of spreadsheets, one for each of the key outputs that is shaped as outlined below. The ultimate aim is to populate each of the blue boxes with the number of individuals demonstrating that combination of factors and where possible the cost to the system of provision for them. Some examples of the types of populations identified within the framework are also outlined, and are highlighted to indicate individuals who may have reached a crisis that has resulted in unplanned or uncoordinated care. Targeting cohorts like this through a integrated care model will provide opportunities for the people to be supported more effectively and pro-actively to avoid or mitigate the impact of any crisis.



Impact of frailty on complexity of care





Analysis of the cohorts with different numbers of frailty support the assumption that as the number of frailty factors increase the level of complex care needs and costs also increases.

The graph on the left shows how the average PBR cost increases for individuals within the homeless frailty factors groups as the number of frailty factors increases.

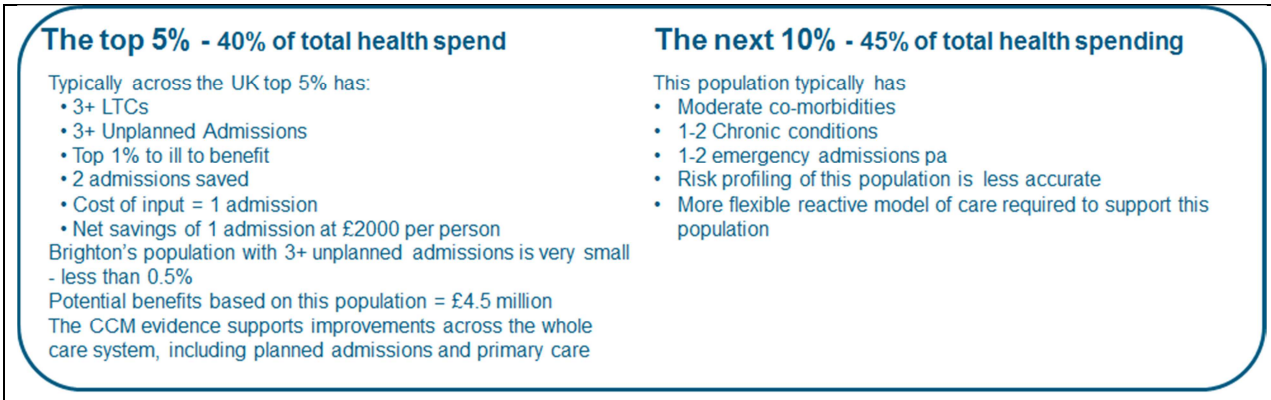
A similar outcome is observed with other key frailty groups (see similar analysis carried out for the over 75's population (above right)

Frailty Framework has been used to inform the design of our integrated care model and enable us to prioritise investment that supports the greatest number of people.

We have developed our integrated care model by building on the chronic care management system that underpins the working of our Integrated Primary Care Teams:

Effective models of Chronic Care Management include all six of the following elements	
1. Self-management support	How we help patients live with their conditions?
2. Delivery system design	Who's on the health care team and in what ways we interact with patients?
3. Decision support	What is the best care and how do we make it happen every time?
4. Clinical information systems	How we capture and use critical information for clinical care?
5. Wider health & social care system	Helping the patient to navigate through the system so that he/she receives joined up support?
6. Leveraging community resources	Getting the best from voluntary organisations and making the most of informal support from neighbours, faith groups etc?

We know from national research that at a high level the top 5% of services users accounts for 40% of health expenditure:



Analysis has shown that the proportion of the Brighton and Hove population with three or more unplanned admissions is very small (less than 0.5%) and the next phase of work we are planning to:

- Undertake further analysis on the co-morbidity and profile of high risk people to understand the low level of emergency admissions
- Further develop our risk stratification model to incorporate mental health data and co-morbidity data from GP systems.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

See Programme Management Plan attached.

b) Please articulate the overarching governance arrangements for integrated care locally

Programme Governance

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

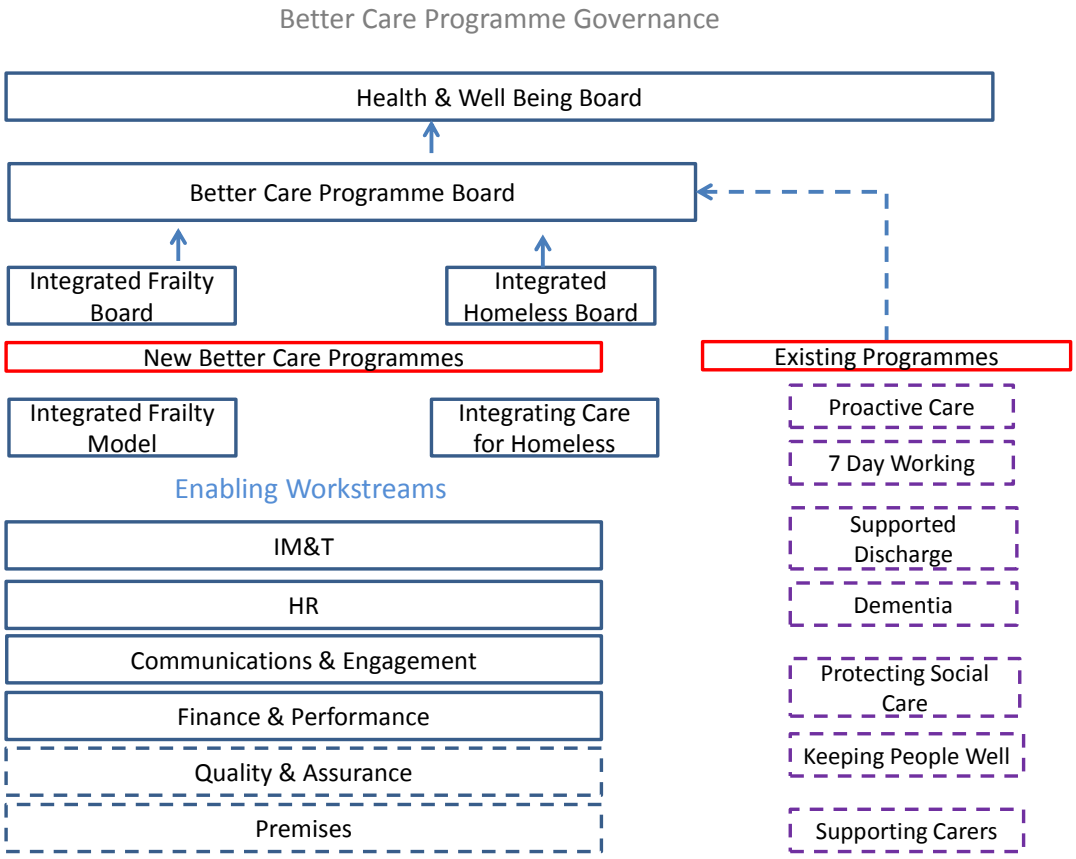
A Better Care Programme Board has been established to oversee the Better Care work programmes. Its main purpose is to provide system wide leadership and accountability for delivery of the Better Care Agenda across Brighton and Hove health and care economy. Overseeing the work of the various Integration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

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

Implementation Boards for Frailty as well as a specific Board for Integrated Homeless Care will

report in to the Better Care Programme Board. Whole System Enabling Work-streams for IM&T, HR, Communications and Engagement, Finance and Performance, Premises and Quality and Assurance will support the overall programme.

The Better Care Programme also compromises a number of existing programmes that will report progress to the Better Care Board. The diagram shown below illustrates the governance arrangements for the programmes.



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Programme Management

The Better Care Programme is a large scale transformational programme spanning health and social care. It has numerous complex interdependencies and therefore requires rigorous and systematic programme management. This approach will help ensure programme success through monitoring progress, identifying areas of concern, allowing sufficient time to mitigate risks and therefore minimise impact on delivery.

The purpose of the Programme Initiation Document (PID) is to set out a framework for delivery of the Better Care Programme of work. The PID describes how the programme is structured, how risks and issues are mitigated and how success will be measured and monitored. The PID is attached in section X.

Approval of the PID, programme plan and budget sits with the Better Care Programme Board. Any significant changes to these documents requires Board approval.

Each of the workstream project boards has the responsibility of making sure that the project documentation is produced and maintained and that the relevant projects are delivered.

Project and Programme Reporting

Programmes and schemes will report into the Better Care Programme Board on a monthly basis. The Integrated Frailty and Homeless Boards will monitor and report on progress on their programmes and report on the following aspects:

- Progress against milestones
- Risks and issues
- Dependencies
- Benefits
- Use of resources/budget against plan

Programme Management Approach

The Better Care Programme will utilise standard programme management tools and techniques based on PRINCE2 methodology.

The Programme documentation will conform to the CCG Project Management Office (PMO) standards and where possible will use existing PMO templates.

The programme plan will contain the key deliverables and milestones from each of the new and existing projects. Each project plan will contain the tasks required to deliver the project outcomes.

Controls

The programme will utilise the following controls to ensure systematic delivery of the programme objectives:

Control	Lead	Approval	Form
Better Care Plan	Programme Manager	Health & Wellbeing Board	National Templates
Programme Initiation	Programme Manager	Better Care Board	PMO standard
Programme Plan	Programme Manager	Better Care Board	PMO standard
Risk log	Programme Manager	Better Care Board	PMO standard/NPSA Matrix
Issue Control	Programme Manager	Better Care Board	PMO standard
Change Control	Programme Manager	Better Care Board	
Update Reports	Project Leads	Workstream Boards	PMO standard
Terms of Reference	Programme Manager	Better Care Board	
Project Documents	Project Leads	Workstream Boards	PMO standard

Table 1: Better Care Fund Programme Controls

Meetings and Reviews

Meeting	Purpose	Frequency
Health and Wellbeing Board	To oversee the integration of health and social care services	Monthly
Better Care Programme Board	provide system wide leadership and accountability for delivery of the Better Care Agenda across Brighton and Hove health and care economy	Monthly
Adult Social Care Modernisation Board	ensure that the work undertaken in response to the introduction of the Care Bill links to the Better Care Programme Board	Quarterly
Implementation Boards	Oversee implementation of New Better Care Projects - Frailty and Homeless	Monthly
Workstream Project Boards	Oversee the delivery of the enabling workstreams	Bi-monthly

Programme Team Meetings	Co-ordinate delivery of the overall programme including all projects and enabling workstreams	Weekly
Project Team Meetings	Delivery of individual projects	Weekly
Metrics Sub-Group	Sub group of the Finance and Performance workstream - to develop programme metrics	Monthly
Planning Sub-Group	Sub group of the Better Care Programme Board to oversee the submission of Better Care Plans	Weekly

Table 2: Better Care Fund Programme Meetings and Reviews

Programme Resources

The Better Care Programme will utilise existing resources within the CCG and Local Authority. In addition to this a Programme Team will be established to deliver the programme. Funding for the additional posts will be through the CCG in 2014/15 and via the pooled budget in subsequent years.

Resource	Description	Period
Programme Manager	Programme Co-ordination and management	2014-2017
Service Development Manager	Co-ordinate operational delivery of the frailty pilot	2014 - 2017
Informatics Project Manager	Develop informatics solutions for each phase of the programme	2014 - 2016
System Analyst	Work with General Practice to implement informatics solution	2015 - 2017
PHB Project Manager	Plan and implement the roll out of PHB	2014 - 2015
Business Analyst	Undertaken benchmarking and performance analysis	2014 -2016
Project Manager	Delivery of homeless project	2014 - 2015
Programme Administrator	Administrative support to the Programme Team	2014 - 2016

Table 3: Better Care Fund Programme Resources

Risk Management

The programme risk management will be undertaken in accordance with the CCG Risk Management Policy and Procedure. The scoring of risk will be done on a likelihood and severity basis using the NPSA risk matrix.

Project risk logs should be updated on an ongoing basis and reviewed monthly by the Project Board. The Programme Risk Log will comprise of the projects risks scored moderate or high and will be reviewed by the Better Care Programme Board on a monthly basis. Following review by the programme board all risks rated as high will be added to the corporate risk register.

Monitoring Performance

The Better Care Programme represents a radical shift in the delivery of services. The new model of working will commence in 14/15 through the proactive primary care project and the Better Care pilots for frailty and homeless. During this period new data will be collected which will give a baseline to measure from in the meantime improvement will be measured against existing targets.

The process for developing the performance reporting data will be overseen by the Finance and Performance Enabling Workstream. The Metrics Sub Group will develop the methodology for data collection and produce monthly performance reports.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Integrated Frailty Teams
2	Integrated Homeless Teams
3	Proactive Care
4	7 Day Working
5	Supported Discharge
6	Dementia
7	Protecting Social Care
8	Keeping People Well
9	Supporting Carers
10	Personalised Care

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	How likely is the risk to material ise?	Potential impact	Overall risk factor	Mitigating Actions
1. The transfer of resources from the acute sector to fund the new models of care does not happen within the required timescales	3	4	12	1. Engage with the acute sector at the planning stage to identify and resources to be transferred. 2. CCG has sufficient non-recurrent funding available to support the transformation as a contingency. 3. Reduce spend on the BC fund if the schemes aren't delivering the planned benefit and utilise reserve funds in the event that benefits realisation is delayed. 4. Discontiue shemes that will not realise benefits. 5. CCG to budget and commission across the integrated pathway by 2016/17. 6. A risk sharing agreement will be developed between the CCG and BHCC to mitigate any loss in funding if the reduction in Emergency admissions is not achieved.
2. There is resistance to change, due to	3	3	9	1. A clear vision for change has been developed and full sign up achieved from all partners 2. Staff engagement events held between Jan

There is a risk that:	How likely is the risk to material ise?	Potential impact	Overall risk factor	Mitigating Actions
lack of buy in from front line staff, which means the delivery of the Integrated Model of Care will fail				and May 2014. 3. Staff involved in co-designing the new model. Workshops being held in August and September 2014. 4. OD strategy developed to support Phase 1 rollout and the homeless pathway, approved at August Better Care Board. 5. Communication and engagement plan being developed to communicate key programme messages and reinforce the vision. 6. Programme has attended partner meetings e.g. Sussex County Trust and Homecare Forum to communicate programme objectives.
3. Providers are not able to make the required changes in capacity and capability and therefore not able to deliver the integrated model of care	3	3	9	1. A multi-agency HR Workstream has been established to oversee the development of an integrated workforce strategy and plan. 2. The CCG is working with the largest providers to ensure that their workforce plans are able to deliver the new integrated model. 3. BHCC Adult Social Care providers are being supported through funding to work in a more responsive way
4. IM&T's ability to create a single care record to support the service change is hindered by a lack of information sharing due to Information Governance constraints.	3	3	9	1. A multi-agency IM&T Workstream has been established to oversee the whole system adoption of the single care record.
5. Phase 2 of the Plans (Full City Roll Out) is not Implemented according to the planned timescales given the complexity of change and wide range of organisations involved	3	4	12	1. Appointment of a senior manager to oversee the Better Care Programme. 2. Robust programme management, governance and assurance processes in place. 3. Agreement to pilot and test first – Phase One of the Plan to ensure learning prior to full roll out. 4. CCG has non-recurrent resources available should the roll out of Phase Two be delayed and the planned financial savings not realised in time.
6. There is a risk to	3	5	15	1. Shared governance arrangements are in place

There is a risk that:	How likely is the risk to material ise?	Potential impact	Overall risk factor	Mitigating Actions
ASC that not meeting the requirements of the BCF will result in the loss of Better Care Funding and therefore the inability to implement the Care Act legal requirements.				in relation to both Better Care and the Care Act to ensure a co-ordinated approach across both programmes. Both programmes share enabling workstreams re workforce, ICT, Communications, Finance and performance.
7. Competing demands for Adult Social Care resource to implement the Care Act, the Modernisation agenda and the reduction in the council's budget may impact on the delivery of the programme.	3	3	9	1. Shared governance arrangements are in place in relation to both Better Care and the Care Act to ensure a co-ordinated approach across both programmes. Both programmes share enabling workstreams re workforce, ICT, Communications, Finance and performance. ASC have secured additional corporate resources to support the implementation of the Care Act. Wherever appropriate the work to implement the Care Act are being aligned to the Better Care programme.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The risks in the deployment of the Better Care Fund are that:

a) We do not have the planned impact on improving outcomes and moving care to an appropriate setting, and
b) 2014/15 investments made do not release the required savings from hospital and community services.

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.

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.

Following the finalisation of the suite of schemes in both years a thorough risk assessment will be undertaken, appropriate interventions identified and the service and financial plans amended if necessary to reflect actual delivery. Any revised plans will ensure we deliver improved outcomes and maintain services.

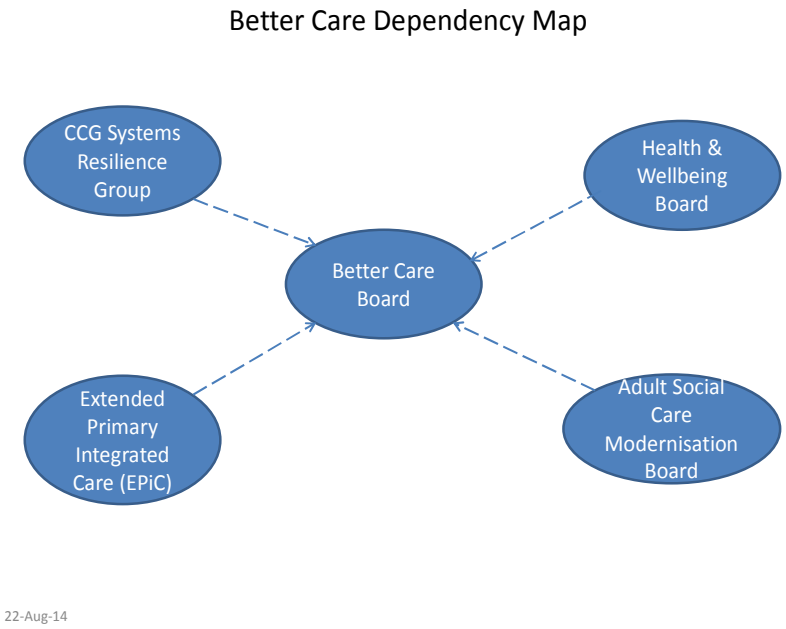
In addition, by the end of 2016/17 we expect to have implemented a programme budgeting approach for a fully integrated frailty pathway. Constituent providers will be working in a formal arrangement under the auspices of a new delivery vehicle and to a shared budget. We will explore options for this over the next two years a we believe this will provide the necessary lever for more effective risk sharing and incentivise further savings from the reactive acute end of the pathway.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Programme Dependencies

The Better care Programme has identified a number of dependencies with other programmes and Boards for both reporting and delivery purposes. The dependency map below identifies some of the key Programmes and Boards that the Better Care Programme will need to report into and keep in touch with their key deliverables.



b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The Better Care Plan aligns with the CCG's strategic vision and objectives as described in our 5 Year Strategic Plan 2014-2019 and our 2 Year Operational Plan 2014-2016.

Our strategic objectives are listed below and annotated to describe the alignment with the Better

Care Plan:

- Align our commissioning to the health needs of our population and ensure we are addressing health inequalities across the City – *the better care plan is based on the findings of the JSNA and aims to reduce the health inequalities in our city by targeting those most vulnerable in our population*
- Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care – *we will employ experience led design as part of the integrated models for frailty and homelessness*
- Increase capacity and capability in primary and community services so that we focus on preventative and proactive care – particularly for the most frail and disadvantaged communities – *our integrated model is based round primary care clusters and aims strengthen community provision*
- Plan services that deliver greater integration between health, social care and housing and promote the use of pooled budgets;
- Design high quality urgent care services that are responsive to patient needs and delivered in the most appropriate setting; the better care plan aims to deliver responsive
- Integrate physical and mental health services to improve outcomes and the health and wellbeing of all our population; *our integrated model is person centred and provides holistic care*
- Deliver a sustainable health system by ensuring our clinical care models, commissioning and procurement processes and internal business practices reflect the broader sustainability agenda and deliver on our duties under the Social Value Act.
- Exploit opportunities provided by technology to deliver truly integrated digital care records, derived from the GP Record as the primary source which will be made 'Fit for caring, fit for sharing' through a programme of information management and data quality initiative

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Primary Care Co-commissioning

Brighton and Hove CCG believe that greater involvement in primary care commissioning presents an exciting opportunity for Clinical Commissioners. It will allow closer alignment of budgets to commissioning strategies, particularly around 'out of hospital' care and could accelerate the delivery of improved quality in primary care by removing some of the existing restraints and barriers.

Our local Primary Care Strategy outlines our hopes and aspirations for primary care now and in the future. It describes a primary care workforce aligned to the needs of the local population, available 7 days a week for routine services and delivering integrated person centred care. We believe that by embracing the co-commissioning opportunity we can more swiftly and effectively deliver these aspirations.

We see high quality primary care as the foundation on which to build the very best healthcare for the population of Brighton and Hove. In order to achieve this we need to increase capacity and capability in primary and community services so that we focus on preventative and proactive care, particularly our most frail and disadvantaged communities. By having greater influence and control of primary care commissioning in this financial year and potentially taking full

responsibility for commissioning and contracting in the future we hope to move at pace to deliver this ambition.

We recognise the benefit of local commissioning and working collaboratively with our members to improve quality and deliver better health care for the city. Our membership is already actively involved in designing and improving local services and we feel co-commissioning is a natural fit with our overall strategy.

We acknowledge the potential conflict of interest that comes with commissioning and contracting primary care but believe that by strengthening existing measures, continuing to operate in an open and transparent way and by executing the contract management function at arm's length and over a wider geographical area we can mitigate this risk.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Protecting Social Care services in Brighton & Hove means ensuring a focus on supporting the most vulnerable people in the City. The eligibility criteria will not change and will remain at 'critical' and 'substantial.' Individuals will have their eligible needs met with an emphasis on ensuring that they are safe.

The implementation of the Care Act in 2015 provides both opportunities and challenges to Councils within this context;

- There will be a significant increase in the number of people who will present for an assessment linked to the funding reform
- More carers will be eligible for both assessments and support in their own right
- More people will have access to advocacy services funded by the Council
- National eligibility will be introduced and the consultation on the regulation / guidance has led to some concern this threshold could be lower than that currently in place
- The information and advice duties placed on the Council will require further development of the existing services
- Funding for implementation of some aspects of the Care Act is included within the Better Care funding

Alongside this significant additional pressures have emerged in relation to Deprivation of Liberty activity following the judgement of the Supreme Court.

In the context of growing demand, budgetary pressures and statutory changes, new and innovative approaches will be required to support people with their care needs

Importance will continue to be 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.

This will mean that Adult Social Care needs to concentrate on the following:

- Remain focused on supporting the most vulnerable people in the city. Safeguarding adults remains a priority;
- Make full use of short term reablement services, equipment, Disabled Facilities Grant, Telecare and Telehealth to promote independence to enable people to fulfil their potential;
- Jointly commission short-term services with the NHS that keep people well at home and support them with a timely discharge from hospital;
- Commission services that offer more choice and more flexible support than traditional models. This includes developing outcomes-based commissioning approaches and using personal budgets creatively and cost effectively;
- Explore and develop cost effective and innovative accommodation solutions (e.g. Extra care housing, supported living) that help people lead independent and fulfilling lives;
- Work with the community and voluntary sector to strengthen assets in local communities to keep people well and prevent them from needing Adult Social Care services;
- Provide good information, advice and signposting services to make people aware of options available to them; this must cover not just adult social care services but the broader range of information and advice including health, housing, finance and other services that can support well being.
- Increasingly, individuals will be purchasing care services using their personal budgets so it will be important that local services are developed to respond to this demand; and
- Support providers who can demonstrate the quality of their services through reducing, minimising or delaying the need for care and maximising independence to deliver better outcomes for individual
- Review and develop the assessment service and look for opportunities to integrate this more closely

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

All of the funding currently allocated in 2013-14 under the Social Care to Benefit Health Grant has been maintained to enable Brighton and Hove City Council to maintain the current eligibility criteria. Whilst the local eligibility criteria will not change in 13/14 , 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 early supported discharge and rapid response services;
- Spending on adult social care to maintain essential services;

- Investments in new services such as additional staffing for bed based short term care services;
- a joint winter contingency the proposals for which will be jointly agreed by health and social care and used to provide additional investment in core services to mitigate winter pressures;
- Support for the independent care sector to ensure timely discharge from hospital; and
- To develop a flexible funding resource that would enable health and social care providers to respond effectively in a coordinated way to changes in demand across systems.
- Further investment in carers services including meeting the requirements of the Care Act from April 2015
- 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
- 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 will be 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.

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

Disabled Facilities Grant

The "Better Outcomes, lower costs' study (ODI/University of Bristol, 2007) confirmed that:

- Timely housing adaptations and appropriate equipment will contribute to supporting people to retain their independence at home. This may also delay the need for home care and other services;
- Adaptations can reduce the risk of falls and injury which would otherwise result in attendance in A&E, or a hospital admission; and
- By supporting people to stay well at home, adaptations can delay the need for an individual to be admitted into a care home.

Preventative services

Brighton and Hove is committed to supporting services that help keep people well and prevent deterioration of physical health and/or emotional well-being. The shift towards more personalised and community based support will continue, giving people more choice control over their care & support.

The recent Commissioning Prospectus (aimed at community & voluntary sector organisations) had a range of outcomes to ensure that service providers in the community & voluntary sector positively promote healthier behaviours and lifestyles. Adult Social Care, Public Health and the CCG worked with providers across the city to support people to make and maintain positive

lifestyle behaviour changes by either offering healthy lifestyle information or signposting as appropriate.

The outcomes identified in the Commissioning Prospectus (2013) for older people's activities were:

- Supporting people to be as independent as possible;
- Reducing social isolation; and
- People remain healthy & well for as long as possible.

The outcomes of the Commissioning Prospectus were developed with providers in the city, and these outcomes will be monitored to measure what difference this will make to local communities.

From April 2014 older people community and voluntary social activities have been commissioned in locality or activity hub areas across the city. There are three activity hubs – east, west and north central. Each activity hub will have a mix of services that include community based groups, befriending services and building based day services.

Activity hubs will work to minimise gaps in service. They will engage other providers to broaden the offer to older people. Home care providers will be encouraged to make people who are socially isolated aware of the activities taking place in their area. Statutory services such as housing, health and council-provided day activities will also be linked into the activity hubs, as will faith groups.

A city wide coordination service supports and develops the activity hubs. They will work on city wide projects that support the activity hubs. These include supporting people to get to activities, supporting volunteering, identifying gaps in services and growing activities.

The gathering of information in local communities and building partnerships with stakeholders in the community & voluntary sector will be a key priority for the Better Care pilot locality area during 2014/15.

In addition to the work in local areas there are a number of initiatives that will support the focus on preventive services:

- Work with the community & voluntary sector to proactively support them to attract and alternative funding opportunities (e.g. Brighton and Hove are through to the second round of the Big Lottery Ageing Better bid);
- Increased support for carers through jointly commissioned support services, better information for carers, greater identification within community services and increasing carers assessments;
- Development of better information signposting & advice services;
- Continued emphasis on personalisation and supporting people to manage their own care;
- Continued investment in Telecare and Telehealth for a wide range of people as a cost effective way of meeting an individual's outcomes and person centred planning support goals;
- Capacity planning with home care and nursing home providers; and
- Home care providers will be encouraged to take a more significant role in identifying solutions to support service users in achieving their outcomes: innovative practice will be important in helping people achieve their goals.

This will result in:

- Timely assessment;
- Care management to facilitate timely discharge from hospital;
- Service delivery to people who have substantial or critical needs;
- Information and Sign-posting to those who are not eligible for Adult Social Care services;
- Funding services in the Community & Voluntary sector;
- More people having an opportunity for reablement;
- Increase in the number of carers' assessments;
- Reduction in the number of people being admitted into a care home.
- Timely response from care home/home care providers to facilitate people being discharged from hospital.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

Protection of social care has been allocated £3.2m in 2014/15 and £5.7m in 2015/16. This includes £0.963m for the implementation of the Care Act.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

A dedicated programme is in place to implement the Care Act with governance arrangements in place that align this programme with the Better Care programme. This includes a Programme Board for each programme with senior management representation from the Council and CCG on both. The two programmes are supported by shared enabling work streams covering communication, ICT, finance , performance and workforce matters.

The Care Act implementation programme includes several dedicated projects focused on themed aspects of the Care Act where local action is required to meet the new duties. These include information and advice, prevention, assessment /review/ care planning, safeguarding, financial assessment/charging , advocacy and carers.

Final regulation and guidance will not be available until October 2014 following the recent extensive consultation.

The costs of implementation in 2015/16 are still being analysed and may shift depending on the final guidance / regulation, however some progress has been made.

Using a national model (Lincolnshire Model) implementation costs for 15 /16 have been identified:

- Early assessments / reviews
- Financial assessments
- Carers Assessments
- Carers support packages

The development of digital Information and Advice services includes investment in a new portal for adult social care which will include enhanced functionality that will provide more personalised

information, the option for self / supported assessment, financial advice and access to individual care accounts. This is being developed to be integrated within an improved shared portal (building on our existing Information Prescriptions site) that provides a full range of Information & Advice across health, housing, well being and the voluntary sector. The capital costs for this will be in the region of £130,000. It will be essential that the final model implemented is sustainable and this will require further investment. There will be further costs to strengthen our capacity to provide Information and Advice through other channels (see Accesspoint).

The demand for additional advocacy is currently being investigated but cannot yet be costed. However without doubt the Care Act will require further investment in advocacy services.

The workforce group is currently developing a workforce strategy that will incorporate the workforce implications of both the Care Act and Better Care ; specific training and awareness programme will be required to support Care Act implementation in April 2015 and again in April 2016 when the funding reforms are introduced..
A significant programme of ICT development has been identified to implement the Care Act covering information and advice, self assessment / service , multi agency information sharing, care accounts, deferred payments arrangements, mobile working, portability of assessment and capturing the NHS number as a unique identifier.

There is concern that the draft regulation and guidance re the national eligibility criteria will set a lower threshold for eligibility than is currently in place. Until the final guidance / regulation is published we cannot estimate the costs of this.

In response to the Care Act and other drivers for change we are undertaking a full business process review and redesign of our assessment, review and care planning functions. This will be aligned to the Better Care programme.

A model detailed financial modelling exercise including the costs of the care funding 2016 in 2016 will be undertaken once the national model for this is available.

v) Please specify the level of resource that will be dedicated to carer-specific support

£0.6m in 2014/15 and £0.9m in 2015/16

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

no significant change

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

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

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

- Community Short Term Services (CSTS) that provide rapid assessment and time-limited support to:
    - Prevent avoidable hospital attendances and/ or admissions;
    - Support service users to recover from a spell of illness/injury following a stay in acute hospital; and
    - Maximise a service user's independence through rehabilitation and reablement
- Brighton Urgent Response Service and Crisis Resolution Home Treatment Team for people with urgent mental health needs.
- Living Well with Dementia Service that provides a 7 day a week service including crisis response.
- Independence at Home is the council's home care service

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

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

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

- General Practice pop-up clinics available at weekends and Bank Holidays;
- Additional Capacity in Community Short Term Services;
- 7 Day Week Medical Consultant support in dementia services;
- Safe Space in the Council where homeless people can go extended to 7 day working; and
- Additional therapy in A&E and on inpatient areas ensuring timely review, assessment and planning.
- Additional hospital & community based social work
- Building on the infrastructure for a robust out of hours service
- Proposals to incentivize care home/ home care providers to respond to referrals out of hours.

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

In addition to this there are plans for:

- Additional Therapy Capacity in IPCT's;
- Additional Therapy Capacity in Community Short Term Services to enable 7 day a week working including a dedicated ambulance;
- Incentivising home care providers and care homes to enable more timely discharge over 7 days, and to put support mechanisms in place for them to respond to requests effectively; and
- Facilitating discharge into Residential and Nursing Care homes with a dedicated resource to support discharge from a hospital bed to an appropriate placement,

helping families, carers and the individual as well as the Homes.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

All health services use the NHS number as the primary identifier in correspondence. As of FY 14/5 NHS Providers now get fined for submitting activity for payment with missing NHS numbers above a 95% threshold.

For care services the BHCC Council system (CareFirst by OLM) has the functionality to include the NHS number but the current primary identifier used is the Carefirst number.

Current performance is that approximately 52% of people using services have their NHS number on the CareFirst system.

BHCC already has an N3 NHS net connection and access to NHS Batch Tracing services, and plan to carry out more batch tracing over the next 12 months to increase NHS No. matching back towards 90%. This will enable record matching across Health and Social Care to support the Phase One pilot. BHCC state: "The Council is committed over the next year to a programme that will ensure the NHS number is provided on the system alongside the Carefirst number as a primary identifier."

Currently this is being progressed through:

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

This work will complete by April 2015.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

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

Multi agency record viewing systems are currently being explored with the Council's main system supplier OLM (e.g. Multi Agency Viewer, MAV), based on open standards e.g. SOA, and whether OLM can connect CareFirst to the Medical Interoperability Gateway ('MIG', run by Healthcare Gateway, which BHCCG has already invested in). We are also deploying Clinical

Correspondence projects to handle GP<->Provider correspondence utilising open standards such as HSCIC's published standard message set in the Interoperability Tool Kit (ITK) which utilises open standards formed from combinations of XML/HL7/CDA. Where specific message formats within ITK already exist (e.g. Sec 2 and Sec 5 Social Care discharge messages) we will look to exploit these as best we can, to support eliminating delayed discharges, for example.

However any progress around ITK is dependent on adoption, design and publication of message formats by HSCIC and subsequent adoption by all suppliers in the chain (providers plus 3 x GP system suppliers). Furthermore we understand GPSoC-R only covers 'rendering' ITK messages in receiving systems aka viewing and not full coded import, which will require additional project work and payment to GP-SoC suppliers.

With support from HSCIC we hope we can overcome these obstacles and we have an open dialog between them and our current providers.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

We are absolutely committed to ensuring that the appropriate IG controls will be in place covering:

- NHS National Standard Contract
- NHS IG Toolkit requirements
- Professional clinical practice
- Caldicott2

To this end:

- Data Sharing agreements will be put in place between the relevant data controllers
- We will review IG training provided
- we will need to test the evolving model with GP Practices not in the pilot to avoid any issues on full roll-out
- Any new systems will have Privacy Impact Assessments completed
- We will establish carefully models of data sharing for new roles such as the Care Co-ordinator (who may be outside both the NHS and BHCC), for any additional organisations we will need to review the contractual arrangements and these will drive the IG approach, are likely to need to complete the NHS IG Toolkit.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Currently, risk stratification of our practice population is a core element of the Integrated Primary Care Team delivery model which is supported by the Risk Profiling and Case Management Directed Enhanced Service. This currently profiles the 2% of those most at risk of emergency hospital admission. Each GP practice identifies individuals at risk of admission using a predictive

tool (the urgent care clinical dashboard) and organises multi-disciplinary team meetings inviting the relevant community practitioners from health social care (both physical and mental health). An action plan is produced for each person discussed and where a person is identified as suitable for case management a lead professional is be identified. This could be a member of the practice team or IPCT, as appropriate to each individual.

This approach to joint assessment and care planning will be built upon as part of our Better Care Programme. Within our Phase One Pilot we will introduce a more pro-active risk stratification and case finding tool. We currently use a risk stratification tool based on attendances and admissions into our acute hospital in order to identify those people at most risk. (Does the tool also include primary care disease registers?) Our intention is to expand the tool to include to include social care, mental health data and other relevant information to provide a more holistic picture of individual's risk. We will aim therefore to identify the top 5% of people within the most frail category and extend the scope of our integrated teams to case manage and co-ordinate care for all people within this cohort.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

See section above

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

The people currently under the care of the IPCTs have care plans in place.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

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

- In February 2013, Age UK Brighton and Hove recorded service user experiences within Community Short Term Services, which is a multi-provider service for intermediate care focussing on avoiding unnecessary hospital admissions and supporting timely discharge from hospital for reablement and rehabilitation. The focus was on systems, processes, and user understanding and satisfaction with care. The outcome of this feedback formed a baseline and has informed future integrated model planning;

- Public events where feedback was sought on key service areas. Themes emerging from specific events on 14th May 2013 and 15th October 2013 highlighted that whilst there are many excellent care and support services available in the City they are not always working well in terms of an overall system of care centred on keeping people well at home;

- A City wide Carers Survey undertaken in November 2012 identified 3 key areas for

improvement:
  - Increase in social contact for carers;
  - Better and more accessible information and advice; and
  - More respite options.

- The Adult Social Care City Summit Event "Have Your Say" was held on 11 June 2013. This was attended by 80 people across the city including those who use services, carers and interested citizens. Some key themes were identified including:
  - The need for different services working closely together;
  - Choice and control in terms of directing care (for example through the use of personal budgets); and
  - Information needs to be easy to access and understand.

- The City's vision for the Integrated Model of Care is described as part of the CCG's Annual Operating Plan for 2014/15 and 2015/16. A public event was held on 13 December 2013 attended by 59 people to gain feedback and input to shaping the plans. One of the workshops asked views on the development of integrated care and key themes were:
  - There was broad support for a more integrated model of care and in particular the need for a system of care co-ordination was identified; and
  - There was potential to expand the role of the community & voluntary sector in terms of a partnership working with health and social care services in an integrated model of care.

Further Public consultation events and feedback mechanisms have been held as an integral part of the Plan to bring a user perspective to developing the programme and ensure that service user and carer views drive the new model of care. There is a public consultation event planned for December 2014 to update on progress of the integrated model and gain feedback.

We have started some specific engagement with a stakeholder event that was held on 5th March 2014.The group consisted of representation from; patients/ service users, carers, health, social care, housing, voluntary sector, independent sector and private sector.

We asked them to consider the following questions:

- Did they agree with our vision?
- What did they see as the challenges and how could they be addressed?
- How would they like to be involved in the future?

People were positive and enthusiastic about the direction of travel but recognised the challenges, for example the sharing of information, the culture change required, as well as trusting one another to rely on a single assessment.

A Citizens Board is in the process of being established, the first meeting is planned for September 2014, to co-ordinate the engagement activity for integrated care in the City. The group will include representation from a range of representative bodies, patients, service users and carers drawn from our Patient Participation Groups and Health Watch. Lead representatives from the Citizens Board will be members of the Frailty and Homeless Implementation Boards.

A communications and engagement strategy and plan is being developed and will be discussed

at the Better Care Board in August.

We have consulted with excluded community's organisations about integrated care to elicit what works well and what could work better. An action plan is being developed from the outputs from the workshops to ensure any particular needs of this group are incorporated into the programme.

We are also seeking external support from an expert in Experience-Led Commissioning/co-design to support the early stages of our integrated care process. This will include working with all partners involved in developing integrated care processes to scope out what a good co-design process would look like, what the training and support needs of partners are, and to work through models with partners and the person receiving care in order to develop a clear, robust and replicable model that can be used as our integrated care programme rolls out across the City. We are keen that users of our local services inform and shape the model and pathways and also contribute to the evaluation and measurement of success.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

There has been a significant emphasis in our local health economy particularly over the past 18 months on how we work as a system, proactively care for frail people, keep them independent and well and provide responsive seven day a week services to avoid unnecessary admission and effectively discharge people when required. Our Better Care plans reflect the priorities for investment of our monthly multi-agency Urgent Care Working Group particularly in relation to 24/7 working and a focus on reablement and effective discharge

Our vision for a more integrated model of care for our frail population was originally initiated by the Urgent Care Clinical Forum – a group of clinicians and social care colleagues representing providers across primary, community and acute settings, the independent, social care and third/voluntary sector. Acknowledging the unsustainable nature of reactive acute based care for this growing cohort of people, the Forum has been working on a new model of care for frailty since September 2013. Their driving principle is to ensure a new model is co-designed and underpinned by widespread professional consensus.

All three major NHS Trusts (Brighton and Sussex University Hospital Trust, Sussex Partnership Foundation Trust, Sussex Community Trust) fully own our Better Care Vision and have helped shape the development of Better Care Plan.

Senior managerial representatives from each of our three major NHS Trusts are represented in all the key governance meetings including:

- The Better Care Board
- The Frailty Board
- The Homeless Board
- Enabling Workstreams such as communications and IM&T

As a system we have been accepted onto the 9-month NHS IQ large scale change programme. All NHS Trusts' executive leads on the Better Care Programme board are participating in this

Organisational Development Programme.

Front line clinicians and operational representatives from each of our three NHS Trusts are also involved in our plans and examples include workshops in July for both homeless and frailty attached at section 1c.

ii) primary care providers

Lead GP's have been key in driving the model of care for frailty and are instrumental in driving forward a co-designed model of care. The Frailty Board is chaired by one of our local GP GP's who is also a member of the CCG Governing Body.

The broader primary care community have an opportunity to contribute to shape our plans through the bi-monthly Local Member Group meetings

We have high level of primary care commitment and as part of plans to test
out our approach to frailty during Phase 1. We invited expressions of interest from our GP practices to test out the model and had responses from over 50% of practices.

GPs, Practice Nurses and Mangers were fully involved in the Frailty Event in July 2014 attached at section 1 c.

iii) social care and providers from the voluntary and community sector

Social care providers and the community and voluntary sector are also fully involved in the design of the Better Care Plans.

The Better Care Board is chaired by Denise D'Souza, Executive Director of Adult Social Care and there is community and voluntary sector representation through the Chief Executive Officer of Community Works (a membership organisation for community and voluntary sector in Brighton and Hove) which provides the sector with information, advice and support and networking opportunities.

We have a thriving community and voluntary sector in Brighton and Hove and have identified that there is huge opportunity to harness the skills and expertise of this sector and they are instrumental to the development and delivery of our integration plans.

The community and voluntary sector are represented on the Better Care Board as well as the Homeless and Frailty Boards and were fully engaged at our most recent events for Frailty and Homeless that took place in July (See section 1c)

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

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 (2014-15 and 2015-16) 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 3.5% (£1.4m) on our current baseline for non-elective admissions could be realised by 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.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description – **See attached scheme descriptions spreadsheet**

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
What is the strategic objective of this scheme?
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	