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

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Brighton and Hove City Council</th>
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<tr>
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b) Authorisation and signoff

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<thead>
<tr>
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<tbody>
<tr>
<td>By</td>
<td>Dr Christa Beesley</td>
</tr>
<tr>
<td>Position</td>
<td>Chief Clinical Accountable Officer</td>
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<tr>
<td>Date</td>
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<table>
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<tbody>
<tr>
<td>By</td>
<td>Catherine Vaughan</td>
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<tr>
<td>Position</td>
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<tr>
<td>By Chair of Health and Wellbeing Board</td>
<td>Councillor Jason Kitcat</td>
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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.

<table>
<thead>
<tr>
<th>Document or information title</th>
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<tbody>
<tr>
<td>Better Care Fund Project Initiation Document</td>
<td>![Project initiation Document FINAL.pdf](Project initiation Document FINAL.pdf)</td>
</tr>
<tr>
<td>Outlines the programme management approach to the Better Care Plan, the associated projects, dependencies and governance arrangements.</td>
<td></td>
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<tr>
<td>• Defines frailty for Brighton &amp; Hove’s community as a group who will benefit from an integrated approach to care in the city</td>
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<td>• Identifies the financial cost of services for the frail population</td>
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<td>• Identifies what is working well in the current system, what needs improving and where there are gaps</td>
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<tr>
<td>• Benchmarks Brighton and Hove against comparators</td>
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</tbody>
</table>
- 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

**Service Map**
A map which shows graphically the range of community health and social care services currently available in Brighton and Hove.

**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 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.

**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.

**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.

**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.

**Report from Homeless Workshop – 11 July**

**Brighton and Hove Joint Strategic Needs Assessment**

**Proactive Care Specification**
Specification for primary care delivery of proactive care for frail and vulnerable people in Brighton and Hove.
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, nationally and internationally, 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.

In our Better Care Plan we address these issues and those more specific to our local population.

**Our Vision for Better Care**

Our vision for our frail population is to help them stay healthy and well by providing more proactive 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.

![Figure 1: Brighton and Hove Vision for Integrated Care](image)

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 later sections:

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 homelessness.

**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, reabiling 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 proactively 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 of which is spent on care homes

![Figure 3: Brighton and Hove CCG and ASC Spend 2013/14](image)

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 spent 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 organisational silos with pockets of service integration, for example mental health services are integrated across health and social care and community short term services are delivered in an integrated way:

![Figure 4: Brighton and Hove Current Configuration of Services](image)

**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. 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 community's 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 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.

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;

![Figure 5: Brighton and Hove Future Configuration of Services](image-url)
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.

Planning Integration

Brighton and Hove CCG has a rigorous approach to planning which is co-ordinated and overseen by the Programme Management Office (PMO). A detailed description of the planning process is contained within the Brighton and Hove Commissioners Handbook and is summarised below:

As part of the planning phase of the Better Care Programme we worked with Capita to define our case for change. The project used the above framework and covered the following areas:

- 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 full case for change is contained in the linked document and summarised below:

Understanding Our Population

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.

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\(^1\) ONS mid-year population estimates for Brighton and Hove 2011
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

The 2011 census highlights the considerable change in the population of Brighton and Hove over the last ten years particularly in respect to our BME population, older people and working age adults. The diagram below the increases and decreases reflected in the census:

**Predicted future need**

Changes in the population age structure affect the need for health and social care services. Population projections therefore have an essential role in assessing the future need for services. Current trends in births, deaths and migration are projected forwards and used to produce population projections.

Over the next ten years we forecast on-going changes to our local population. The resident population is predicted to rise to 289,900 by 2021 (6% increase from 2011) –16,900 more people. The greatest projected rise will be seen in the 25-34 & 50-59 year age groups. There are also projected to be higher numbers of children under 15 years. The number of people aged 75 years or over is expected to rise by 10% from 18,272 in 2011 to 20,085 in 2021. We also forecast a rise in the number students associated with the expansion of the existing Universities in the City.

**Key population groups within the city**
Brighton and Hove City has a unique and diverse population. The following are some of the key population groups within the city and considered in our plans:

- **BME groups** – The 2011 Census shows that 19.5% of the city’s population are from a BME group.
- **LGB** - Estimates suggest that there may be 40,000 people from Lesbian, Gay, Bisexual (LGB) communities living in Brighton & Hove, around 15% of the city’s population.
- **Carers** - 9% of the population (approximately 24,000 people)
- **Migrants** - 2010 figures show that 15% of the city’s population was born abroad.
- **Students** - there has been an increase in the numbers of students in the city to more than 35,200 in 2011/12. This is approximately 13% of the total population.
- **Military veterans** – an estimated 17,400 military veterans live in the city.
- **Gypsies and travellers** – an estimated 198 gypsies and travellers
- **Homeless** – there are approx. 3000 homeless people in Brighton and Hove

In terms of the highest levels of need for excluded communities, local research (Public Health needs assessments and others) has shown that the most acute and worrying needs exist for Traveller, Transgender and Homeless people.

**Joint Strategic Needs Assessment (JSNA)**
We identify need by working with public health staff to develop the overview of local health and wellbeing needs, and inequalities, known as the Joint Strategic Needs Assessment (JSNA). This comprehensive document also takes account of the patient voice, benchmarking and activity data, and quality indicators.

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

The JSNA identified five key health needs in the city:

- **Cancer** and screening access: Mortality from all cancers in under 75 year olds is significantly higher in Brighton and Hove than England and the South East. There are three NHS cancer screening programmes in England: breast, cervical and bowel and in Brighton & Hove, screening uptake rates are generally lower than both regional and national figures. Cancer and cancer screening is identified as one of the five priorities in the Joint Health and Wellbeing Strategy (JHWS) and is identified as one of the components of frailty in the Better Care Programme.

- **Diabetes**: The prevalence of diabetes is increasing nationally due to increased obesity, an aging population and increasing numbers of South Asian people, who are at greater risk of developing diabetes. In Brighton & Hove numbers have also increased with 3.3% of people registered with GPs having diabetes in 2012 compared with 2.9% in 2008. The Better Care Programme will include people with long term conditions helping them to manage their condition and stay well.

- **Dementia**: It is estimated that there are currently almost three thousand people aged 65 years or over with dementia in Brighton & Hove. However this is lower than expected prevalence and therefore more needs to be done to identify this cohort. The CCG have jointly developed with Brighton and Hove City Council a Dementia Plan which describes how we will deliver local improvements in line with the National Dementia Strategy and raise dementia diagnosis rates to 67% by March 2015. Dementia is a key part of the Better Care Plan and we have selected as our local indicator dementia diagnosis rate.

- **Musculoskeletal conditions**: Musculoskeletal conditions are a range of conditions including back pain, shoulder pain, hip and knee pain which can limit mobility in older people and make them
vulnerable to falls. In each year it is estimated that about 40% of the adult population have low back pain, 5% have hip pain and 60% of over 65s severe knee pain. Brighton and Hove has a high programme budget spend in this area yet has poor patient reported outcomes. The Better Care Programme will ensure that people are holistically assessed and managed ensuring that people can stay mobile and independent for longer.

**Coronary Heart Disease:** Despite reductions over recent decades, coronary heart disease remains the most common cause of death nationally. It was the main cause of death for 218 people in Brighton & Hove in 2011 which was approximately 10% of all deaths. In 2011/12 2.3% of all patients registered local GPs had coronary heart disease. The Better Care Programme will include people with long term conditions helping them to manage their condition and stay well

Some of the other 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 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.

**How do we compare?**

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\(^2\) Identified by the 2013 Brighton and Hove Joint Strategic Needs Assessment
Only by understanding how the health and social care system is currently performing can we evaluate the potential for generating quality and financial improvements through an integrated model of care.

Brighton and Hove has been compared against the following peer group based on a weighted comparison of location, profile and deprivation:

- NHS HASTINGS AND ROTHER CCG
- NHS EALING CCG
- NHS ENFIELD CCG
- NHS PORTSMOUTH CCG
- NHS SLOUGH CCG
- NHS LUTON CCG
- NHS SOUTHAMPTON CCG
- NHS BRISTOL CCG
- NHS CAMDEN CCG
- NHS THANET CCG
- NHS CORBY CCG
- NHS WANDSWORTH CCG
- NHS CROYDON CCG
- NHS LINCOLNSHIRE EAST CCG
- NHS HAMMERSMITH AND FULHAM CCG
- NHS SHEFFIELD CCG
- NHS NORTH EAST LINCOLNSHIRE CC

The table below shows some high level indicators versus the peer group selection, including the current rates, percentile, and the 75th percentile performance of the peer group. All comparisons are standardised by age and gender to give a more comparative view.

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<td>Admission Rates Emergency</td>
<td>93.14</td>
<td>55%</td>
<td>88.55</td>
</tr>
</tbody>
</table>

Table 1: Brighton and Hove Hospital Activity Benchmarking

The figures show a general high level of performance in terms of total and planned admission rates, and also the city performs better than average against its ONS comparators for emergency admissions. There may be scope to improve rates of outpatient referrals into the acute providers through shifting the provision of outpatient services beyond the front-door of the Trust.

The integrated frailty model would support the delivery of more proactive care to be provided within the community avoiding unnecessary emergency acute episodes. The provision of a broader range of enhanced integrated services would also enable more traditional outpatients’ services to be delivered within the community.

Data suggest that when compared to comparators Brighton and Hove have comparatively fewer homecare service users than elsewhere. There could be a number of reasons for this one being that potential support being provided by the city’s active voluntary sector is having a positive effect on maintaining the independence of many of those who are in the lower levels of frailty.
Whilst the number of nights of residential and nursing care is relatively low the unit costs for provision are high. Consideration should be given as to whether this high cost is driven by market forces alone or whether high costs are a reflection of high quality that can be built upon as part of partnership working in the implementation of the integrated care model for those whose independence is unavoidably limited to residential care.

Whilst usage of residential and nursing care is low, there remains the opportunity through better communication and integration of services to sustain care for more individuals at home for longer.

Where residential and nursing care provides a suitable short term service for frail individuals (for example those leaving hospital following an acute event), a successful integrated care model with improved communication between services has significant potential to increase the numbers of people who are supported to “step-down” into less intensive social care services.

In Brighton it is estimated that 9% of the population (approximately 24,000 people) identify themselves as carers.

Comparative data suggest that the numbers of carers receiving information and advice and carers services across the city are average when compared to peers. This does however mean that there is scope to consider further the support that could be provided to carers as valuable members of the team supporting frail individuals within Brighton and Hove.

Engagement with carers in relation to the design and delivery of services is crucial to ensuring that statutory and voluntary services work in tandem with the support being provided by friends and family reducing risk of carer breakdown and increased pressure on CCG and Council resources.
Comparisons of Home Care Service User Surveys show that in general users of Brighton & Hove ASC services have high levels of satisfaction of the services they receive. Service Users feel that the services help them have a better quality of life and in general ASC service users have a high levels of satisfaction with their quality of life.

Brighton and Hove commissioning plans describe a focus on pro-active support for patients with Mental Health disorders and this is reflected in an increased investment for MH services. Spend on substance misuse appears 23% more than peers however spend on MH Health Promotion is 74% less than peers:

As stated previously this general level of good performance means that Brighton & Hove is in a robust position to shift the way care is provided, utilising the relative strength of social care provision to support better integration of care to enable people to maintain their quality of life and independence.

**Population Segmentation and Risk Stratification**

As part of our analysis work we grouped the local population based on utilisation risk; that is the likelihood that a person will use services. We used the Urgent Care Dashboard to stratify the population based on risk of unplanned hospital admission. This helped us identify the cohort of patients that were most likely to have an unplanned hospital attendance (approx. 2% of our population). We recognised that we needed to look at our population in a different way to fully
understand our frail cohort and the services they need. In practical terms frail people can be defined by:

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

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. The first population segment we looked at was those with single factors which alone would define someone as frail:

<table>
<thead>
<tr>
<th>Single Factor</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipients of Social Care Funded <strong>Home Care</strong></td>
<td></td>
</tr>
<tr>
<td>Social Care funded residents in <strong>Residential Care</strong></td>
<td></td>
</tr>
<tr>
<td>Social Care funded residents in <strong>Nursing Care</strong></td>
<td></td>
</tr>
<tr>
<td>Recipients of <strong>Continuing Health Care</strong></td>
<td></td>
</tr>
<tr>
<td>People currently receiving services from the <strong>IPCT</strong></td>
<td></td>
</tr>
<tr>
<td>Mental Health service users on <strong>CPA</strong></td>
<td></td>
</tr>
<tr>
<td>Individual in receipt of an <strong>End of Life programmes</strong></td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Brighton and Hove Factors Determining Frailty

Next we looked at those with characteristics that in combination contribute to an individual being identified as being frail. We 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 was then cross referenced with one or two other cross-referencing factors:

<table>
<thead>
<tr>
<th>Key Factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Homelessness</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Aged over 80</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Having a learning disability</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Under 65 but with more than two emergency hospital admissions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Aged between 65 and 85 (requires two additional factors not one)</strong></td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Brighton and Hove Factors Indicating Frailty

These cross-referencing factors were developed following 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.
### Table 4: Brighton and Hove Factors Indicating Potential Frailty

<table>
<thead>
<tr>
<th>Cross Referencing Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than one emergency admission to hospital in a year</td>
</tr>
<tr>
<td>Dementia diagnosis (incl. secondary diagnoses)</td>
</tr>
<tr>
<td>Multiple A&amp;E attendances</td>
</tr>
<tr>
<td>Repeat DNAs (3 or more within a year)</td>
</tr>
<tr>
<td>Alcohol/substance abuse-related admission</td>
</tr>
<tr>
<td>Long Term Conditions</td>
</tr>
<tr>
<td>Co-morbidities</td>
</tr>
<tr>
<td>Vision Impaired</td>
</tr>
</tbody>
</table>
| 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               |

Analysis of Frail Population Service Use

Analysis of the patient cohorts with different numbers of frailty factors 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 (below right):

![Graph of average PBR cost per patient for homeless patients](image1)

![Graph of average PBR cost per patient for patients who are 75 or older](image2)

**Figure 12: Brighton and Hove Cost of Frailty**

People age 65-84 account for 11% of population and 30% of people with multiple emergency admissions in the year. Over 85s – account for just 2% of population but 20% of people with multiple emergency admissions:
The share of those with multiple emergency admissions under 65 is 50%. The table below shows the top 10 admitted diagnosis for those patients with multiple emergency admissions under 65.

There is little published evidence on national trends of emergency admission diagnosis for under 65s to know if this distribution is unusual:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>B349 Viral infection, unspecified</td>
<td>82</td>
</tr>
<tr>
<td>R074 Chest pain, unspecified</td>
<td>66</td>
</tr>
<tr>
<td>J450 Asthma, unspecified</td>
<td>58</td>
</tr>
<tr>
<td>R103 Pain localized to other parts of lower abdomen</td>
<td>49</td>
</tr>
<tr>
<td>R51X Headache</td>
<td>42</td>
</tr>
<tr>
<td>N350 Urinary tract infection, site not specified</td>
<td>40</td>
</tr>
<tr>
<td>R104 Other and unspecified abdominal pain</td>
<td>39</td>
</tr>
<tr>
<td>T391 4-Aminophenol derivatives</td>
<td>38</td>
</tr>
<tr>
<td>R458 Other symptoms and signs involving emotional state</td>
<td>31</td>
</tr>
<tr>
<td>J22X Unspecified acute lower respiratory infection</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 5: Top 10 diagnosis codes for Under 65 Emergency Admissions

Based on this analysis it is unlikely that reductions in cost of emergency admissions for this cohort alone would off-set the costs of implementation of an integrated care model. The evidence however shows that CCM will support improvements in the whole system of care including reductions in planned admissions and potential to improve other aspects of care including in primary care.

Evidence Based Model

We have used the Chronic Care Model for managing patients with frailty to inform our proposals. The model is endorsed by the Kings Fund. For example it underpins their video on integrated care featuring a cameo patient “Sam’s Story”.

CCM was developed by Edward Wagner and colleagues at the MacColl Institute for Healthcare Innovation in the US. It was developed from a review of randomised trials of interventions by primary care clinicians to support people with long term conditions and frailty.

In the study, interventions were classified into 6 domains. One key finding was that effectiveness increases with the number of domains included in a package of interventions. Furthermore,
patient self-management is crucial to the overall success of the package.

Another finding was that variations in performance within practices is greater than between practices. Hence, there was a shift away from benchmarking practices to a focus on improving practice management to make delivery more systematic.

Outcomes
Brighton and Hove CCG Better Care Team have been working with the NHS improving Quality team to focus on practical tools and approaches that will support us in delivering the large scale transformational change needed, through the Better Care programme.

A series of workshops have been held which were designed in partnership with the NHSIQ team and the local area to deliver coaching and training in the areas we feels will benefit the programme most.

The fourth workshop focussed on the exploring a range of issues and challenges concerning the measurement of success in delivering our strategy. This included a review of existing data and techniques for developing key metrics and outcomes to our strategy.

The workshop focussed on introducing a technique to identify the primary and secondary drivers for the programme and ensure that these are linked to the metrics. We used the workshop to focus on, Care Homes and Avoidable Admissions. The output on avoidable admissions is illustrated below.
Having determined our primary and secondary drivers, we then used a technique to develop measures and metrics aligned to the drivers. A fourth area to consider was a balancing measure to ensure we could measure any unintended consequences of the changes proposed. This is illustrated below;

Since the workshop, we have rolled this process this out internally across the other better care schemes. For each project a set of key performance indicators has been developed which will be monitored by the individual projects and the Finance and Performance Board. The KPIs are contained at the end of Annex 1.

**Financial Analysis**

The research evidence shows that top 5% of the population based on risk profiling, are likely to account for 40% of health spend and have 3 or more long term conditions and a risk of 3 or more unplanned admissions over 12 months. For this cohort chronic care management would deflect an average of 2 admissions, however, the additional primary care costs would equate to 1 admission, so potentially a saving of £1,490 per person could be generated based on this evidence.
Of this cohort, 4 out 5 are likely to avoid admissions through intense chronic care management. The remaining 20% of individuals in this cohort are likely to have such significant levels of need that proactive case-management is unlikely to reduce their number of admissions, although in terms of quality of life and care CCM will provide benefits for these people as well.

However, analysis purely of the population with three or more emergency admissions suggests that only 1279 or less than 0.5% of the population meet this criteria. Therefore the savings associated with the roll out of the frailty project were estimated as follows:

<table>
<thead>
<tr>
<th></th>
<th>actual</th>
<th>Top 1%</th>
<th>Moderately frail (4%)</th>
<th>Unit Cost</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 or more admissions in last 12 months</td>
<td>1279</td>
<td>255.8</td>
<td>1023.2</td>
<td>£1,490</td>
<td>£1,524,568</td>
</tr>
</tbody>
</table>

Table 6: Brighton and Hove Multiple Emergency Admissions, Source: SUS Data

Since the initial case for change was developed we have worked with each of the project teams and identified savings by scheme:

<table>
<thead>
<tr>
<th></th>
<th>Change in activity measure</th>
<th>Unit Price (£)</th>
<th>Total (Saving) (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Frailty Model</td>
<td>43</td>
<td>£1,490</td>
<td>£64,070</td>
</tr>
<tr>
<td>Integrated Homeless Model</td>
<td>5</td>
<td>£1,490</td>
<td>£7,450</td>
</tr>
<tr>
<td>Proactive Care - Primary Care</td>
<td>21</td>
<td>£1,490</td>
<td>£31,290</td>
</tr>
<tr>
<td>Proactive Care - CRRS</td>
<td>182</td>
<td>£1,490</td>
<td>£271,180</td>
</tr>
<tr>
<td>keeping people healthy</td>
<td>53</td>
<td>£1,490</td>
<td>£78,970</td>
</tr>
<tr>
<td></td>
<td>304</td>
<td></td>
<td>£452,960</td>
</tr>
<tr>
<td>2015/16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Frailty Model</td>
<td>170</td>
<td>£1,490</td>
<td>£253,300</td>
</tr>
<tr>
<td>7 day working</td>
<td>68</td>
<td>£1,490</td>
<td>£101,320</td>
</tr>
<tr>
<td>Proactive Care</td>
<td>191</td>
<td>£1,490</td>
<td>£284,590</td>
</tr>
<tr>
<td>Integrated Homeless Model</td>
<td>20</td>
<td>£1,490</td>
<td>£29,800</td>
</tr>
<tr>
<td>Proactive Care - CRRS</td>
<td>354</td>
<td>£1,490</td>
<td>£527,460</td>
</tr>
<tr>
<td></td>
<td>803</td>
<td></td>
<td>£1,196,470</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non elective savings</td>
<td></td>
<td></td>
<td>£1,649,430</td>
</tr>
</tbody>
</table>

Table 7: Better Care Fund Savings Calculations. Source: Part 2 Template

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

**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:

- **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;

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>KM 1</td>
<td>Development of Phase One frailty model: clinical pathways, thresholds and processes &amp; care plans, governance and quality</td>
<td>Sep-14</td>
</tr>
<tr>
<td>KM 2</td>
<td>Phase1 Multidisciplinary team in place</td>
<td>Oct-14</td>
</tr>
<tr>
<td>KM 3</td>
<td>Evaluation of Phase One</td>
<td>Apr-15 to Jun-15</td>
</tr>
<tr>
<td>KM 4</td>
<td>Develop plans for full City roll out based on evaluation of Phase 1</td>
<td>Jul-15 to Sep-15</td>
</tr>
<tr>
<td>KM 5</td>
<td>Full City Implementation</td>
<td>from Apr-16</td>
</tr>
</tbody>
</table>

Table 8: Key Milestones Integrated Frailty Model

We have sought support from an expert in Experience-Led Commissioning/co-design to work with users of our local services to inform and shape the model and pathways and also contribute to the evaluation and measurement of success.

This resource will be in place by October 2014 and, together with the CVS will design a user survey to understand the patient experience in relation to the delivery of integrated care and allow us to develop a system which measures patient experience of integration over time, allowing any improvements to be demonstrated.
We will develop the patient/user experience metric and ensure that it meets the SMART criteria and is targeted at the population for both Frail and Homeless citizens.

Our patient/user experience survey and metric will be centred around the core areas of improvement we are trying to make regarding patient experience and allow patients and users to have a say in how those services develop.

**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.

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>KM 1</td>
<td>Interim projects evaluation (6 months)</td>
<td>Apr-14 to Oct-14</td>
</tr>
<tr>
<td>KM 2</td>
<td>Development of integrated homeless hub and spoke model including governance quality, KPI’s</td>
<td>Sep-14 to Mar-15</td>
</tr>
<tr>
<td>KM 3</td>
<td>Evaluation of learning from homeless joint working projects</td>
<td>Oct -14 to June 15</td>
</tr>
<tr>
<td>KM 4</td>
<td>Business Case for Homeless Model approved</td>
<td>Sep-15</td>
</tr>
<tr>
<td>KM 5</td>
<td>Mobilisation plans</td>
<td>Sep -15 to April 16</td>
</tr>
<tr>
<td>KM 6</td>
<td>Homeless Hub and Spoke Model Starts</td>
<td>From Apr-16</td>
</tr>
</tbody>
</table>

Table 9: Key Milestones Integrating Care for homeless people

We will also develop a patient/user survey to evaluate the success of the MDT approach as outlined in detail in the Integrated Frailty model section of the plan.

**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:

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>KM 1</td>
<td>Strengthen existing services</td>
<td>Apr-14</td>
</tr>
<tr>
<td>KM 2</td>
<td>Develop Primary Care Proactive Care model</td>
<td>May-14 to Nov-14</td>
</tr>
<tr>
<td>KM 3</td>
<td>Implement Primary Care Proactive Care model</td>
<td>Dec-14</td>
</tr>
<tr>
<td>KM 4</td>
<td>Evaluate impact of proactive care programme</td>
<td></td>
</tr>
<tr>
<td>KM 5</td>
<td>Review the role of the SW in the IPCT’s and agree additional services to be evaluated</td>
<td>Oct-14</td>
</tr>
</tbody>
</table>

Table 10: Key Milestones Proactive Care

**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.

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>KM 1</td>
<td>Arrangements/Processes established to provide PHBs to all CHC patients who wish to receive them</td>
<td>Oct-14</td>
</tr>
<tr>
<td>KM 2</td>
<td>Agree extension of PHB project into Better Care Frailty (Phase 1)/Homeless projects</td>
<td>Sept/Oct 14</td>
</tr>
<tr>
<td>KM 3</td>
<td>Agree arrangements for managing/monitoring PHBs for children with Complex Needs</td>
<td>Dec-14</td>
</tr>
<tr>
<td>KM 4</td>
<td>Application to participate in Integrated Personalised Commissioning Programme</td>
<td>post Sept 14</td>
</tr>
<tr>
<td>KM 5</td>
<td>Collate/Evaluate learning from 14-15 project to inform extension of PHBs in 15-16</td>
<td>Jan/March 15</td>
</tr>
</tbody>
</table>

Table 11: Key Milestones Personalised Care

**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 out of the new model of care in 2016/17.

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>KM 1</td>
<td>Additional therapist in STS</td>
<td>Nov-14</td>
</tr>
<tr>
<td>KM 2</td>
<td>CareLink in place</td>
<td>Jan-15</td>
</tr>
</tbody>
</table>
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.

Table 12: Key Milestones 7 Day Working

<table>
<thead>
<tr>
<th>KM</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>KM 3</td>
<td>Extension for ICES</td>
<td>Dec-14</td>
</tr>
<tr>
<td>KM 4</td>
<td>Additional Care Managers working across the City localities 7 days per week</td>
<td>Jan-15</td>
</tr>
</tbody>
</table>

Table 13: Key Milestones Supported Discharge

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.

Table 14: Key Milestones Better identification of people with dementia

<table>
<thead>
<tr>
<th>KM</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>KM 1</td>
<td>2014-2017 Dementia Plan approved by Health and Wellbeing Board</td>
<td>Oct-14</td>
</tr>
<tr>
<td>KM 2</td>
<td>Primary Care Support launched to improve dementia diagnosis rate</td>
<td>Nov-14</td>
</tr>
</tbody>
</table>
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.

### Table 15: Key Milestones Supporting Carers

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>KM 1</td>
<td>Project starts</td>
<td>Sep-14</td>
</tr>
<tr>
<td>KM 2</td>
<td>Collect first quarter data</td>
<td>Dec-14</td>
</tr>
<tr>
<td>KM 3</td>
<td>Annual ASC Carers Survey with data being released in March’15.</td>
<td>Nov-14</td>
</tr>
<tr>
<td>KM 4</td>
<td>Results analysed and communicated</td>
<td>Mar-15</td>
</tr>
</tbody>
</table>

### 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.
KM 1 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. TBC

KM 2 Further investment in carers services including meeting the requirements of the Care Act Apr-15

KM 3 Further investment in advocacy services in response to the Care Act requirements from April 2015 TBC

KM 4 Development of better information signposting & advice services TBC

**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.
### Description

| KM 1 | Work with the community & voluntary sector to proactively support them to attract and alternative funding opportunities | TBC |
| KM 2 | Develop better information signposting & advice services | TBC |
| KM 3 | Launch online portal | Mar-15 |

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 1c).

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 individual 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:

<table>
<thead>
<tr>
<th>Control</th>
<th>Lead</th>
<th>Approval</th>
<th>Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Care Plan</td>
<td>Programme Manager</td>
<td>Health &amp; Wellbeing Board</td>
<td>National Templates</td>
</tr>
<tr>
<td>Programme Initiation</td>
<td>Programme Manager</td>
<td>Better Care Board</td>
<td>PMO standard</td>
</tr>
<tr>
<td>Programme Plan</td>
<td>Programme Manager</td>
<td>Better Care Board</td>
<td>PMO standard</td>
</tr>
<tr>
<td>Risk log</td>
<td>Programme Manager</td>
<td>Better Care Board</td>
<td>PMO standard/NPSA Matrix</td>
</tr>
<tr>
<td>Issue Control</td>
<td>Programme Manager</td>
<td>Better Care Board</td>
<td>PMO standard</td>
</tr>
<tr>
<td>Change Control</td>
<td>Programme Manager</td>
<td>Better Care Board</td>
<td></td>
</tr>
<tr>
<td>Update Reports</td>
<td>Project Leads</td>
<td>Workstream Boards</td>
<td>PMO standard</td>
</tr>
<tr>
<td>Terms of Reference</td>
<td>Programme Manager</td>
<td>Better Care Board</td>
<td></td>
</tr>
<tr>
<td>Project Documents</td>
<td>Project Leads</td>
<td>Workstream Boards</td>
<td>PMO standard</td>
</tr>
</tbody>
</table>

Table 16: Better Care Fund Programme Controls

**Meetings and Reviews**

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Purpose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Wellbeing Board</td>
<td>To oversee the integration of health and social care services provide system wide leadership and accountability for delivery of the Better Care Agenda across Brighton and Hove health and care economy</td>
<td>Monthly</td>
</tr>
<tr>
<td>Better Care Programme Board</td>
<td></td>
<td>Monthly</td>
</tr>
<tr>
<td>Adult Social Care Modernisation Board</td>
<td>ensure that the work undertaken in response to the introduction of the Care Bill links to the Better Care Programme Board</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Implementation Boards</td>
<td>Oversee implementation of New Better Care Projects - Frailty and Homeless</td>
<td>Monthly</td>
</tr>
<tr>
<td>Workstream Project Boards</td>
<td>Oversee the delivery of the enabling workstreams</td>
<td>Bi-monthly</td>
</tr>
<tr>
<td>Programme Team Meetings</td>
<td>Co-ordinate delivery of the overall programme including all projects and enabling workstreams</td>
<td>Weekly</td>
</tr>
<tr>
<td>Project Team Meetings</td>
<td>Delivery of individual projects</td>
<td>Weekly</td>
</tr>
<tr>
<td>Metrics Sub-Group</td>
<td>Sub group of the Finance and Performance workstream - to develop programme metrics</td>
<td>Monthly</td>
</tr>
<tr>
<td>Planning Sub-Group</td>
<td>Sub group of the Better Care Programme Board to oversee the</td>
<td>Weekly</td>
</tr>
</tbody>
</table>
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.

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

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.

<table>
<thead>
<tr>
<th>Ref no.</th>
<th>Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7 Day Working</td>
</tr>
<tr>
<td>2</td>
<td>Proactive Care</td>
</tr>
<tr>
<td>3</td>
<td>Supported Discharge</td>
</tr>
</tbody>
</table>
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.

i) Comprehensive risk logs will be put in place at scheme and Programme level to manage or mitigate our known risks and any emerging risks associated with the plan. The Programme Risk Log will be reviewed monthly at the Better Care Programme Board and the scheme risks at the relevant steering group. Any scheme risks deemed as “high risk” will be escalated to the Board for action. Below are the risks and mitigating actions for the Programme.

<table>
<thead>
<tr>
<th>There is a risk that:</th>
<th>How likely is the risk to materialise?</th>
<th>Potential impact</th>
<th>Overall risk factor</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Finance</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>1. We will engage with the acute sector at the planning stage to identify and resources to be transferred.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. We are developing business cases for each scheme which will identify the expected financial flows and activity reductions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Identify and put in place checkpoints to assess the progress of schemes and discontinue schemes that will not realise benefits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. We will 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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5. The CCG has sufficient non-recurrent funding available to support the transformation as a contingency.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6. CCG to budget and commission across the integrated pathway by 2016/17.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7. 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.</td>
</tr>
<tr>
<td>2. Finance</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>1. Shared governance arrangements are in place</td>
</tr>
<tr>
<td>There is a risk that:</td>
<td>How likely is the risk to materialise?</td>
<td>Potential impact</td>
<td>Overall risk factor</td>
<td>Mitigating Actions</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------</td>
<td>-----------------</td>
<td>--------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>There is a risk to ASC that not meeting the requirements of the BCF will result in the loss of Better Care Funding from 2016/17 and therefore the inability to implement the Care Act legal requirements.</td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>3. HR/Workforce</td>
<td>There is resistance to change, due to lack of buy in from front line staff, which means the delivery of the Integrated Model of Care will fail</td>
<td>3</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>1. A clear vision for change has been developed and full sign up achieved from all partners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Staff engagement events held between Jan and May 2014.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Staff involved in co-designing the new model. Workshops being held in August and September 2014.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. OD strategy developed to support Phase 1 rollout and the homeless pathway, approved at August Better Care Board.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Communication and engagement plan being developed to communicate key programme messages and reinforce the vision.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Programme has attended partner meetings e.g. Sussex County Trust and Homecare Forum to communicate programme objectives.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. HR/Workforce:</td>
<td>Providers are not able to make the required changes in capacity and capability and therefore not able to deliver the integrated model of care</td>
<td>3</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>1. A multi-agency HR Workstream has been established to oversee the development of an integrated workforce strategy and plan.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. The CCG is working with the largest providers to ensure that their workforce plans are able to deliver the new integrated model.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. BHCC Adult Social Care providers are being supported through funding to work in a more responsive way</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. HR/Workforce:</td>
<td>Competing demands for Adult Social Care resource to implement the Care Act, the</td>
<td>3</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>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</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a risk that:</td>
<td>How likely is the risk to materialise?</td>
<td>Potential impact</td>
<td>Overall risk factor</td>
<td>Mitigating Actions</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>------------------</td>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Modernisation agenda and the reduction in the council’s budget may impact on the delivery of the programme.</td>
<td></td>
<td></td>
<td></td>
<td>resources to support the implementation of the Care Act. Wherever appropriate the work to implement the Care Act is being aligned to the Better Care programme.</td>
</tr>
<tr>
<td>6. <strong>Information Governance:</strong> IMM&amp;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.</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>1. A multi-agency IM&amp;T Workstream has been established to oversee the whole system adoption of the single care record.</td>
</tr>
<tr>
<td>7. <strong>Performance:</strong> 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</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>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.</td>
</tr>
<tr>
<td>8. <strong>Performance:</strong> The BCF programme is ambitious in scale, containing 9 delivery and 6 enabling programmes. There is a risk that there are too many initiatives for the CCG, the Council and its partners to give the necessary focus on these and therefore impede</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>1. Each scheme will be monitored through the PMO against delivery of milestones and benefits 2. Gateways will be put in place to assess the success of each scheme and those that are not delivering will be discontinued</td>
</tr>
</tbody>
</table>
There is a risk that:

<table>
<thead>
<tr>
<th>How likely is the risk to materialise?</th>
<th>Potential impact</th>
<th>Overall risk factor</th>
<th>Mitigating Actions</th>
</tr>
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<tr>
<td>delivery</td>
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9. **Performance:**
Schemes identified do not deliver the expected reduction in activity

| 4 | 3 | 12 |

1. A monitoring and performance dashboard is being developed to track schemes deliverables and achievement against planned targets. Remedial action will be taken for any schemes that are not performing.

10. **Reputational Risk**
There is a risk to our reputation with patients and our providers if the BCF schemes do not deliver

| 4 | 2 | 8 |

1. Providers and the VCS have been involved in developing the programme from the beginning and consulted at each stage of its development and are part of the Better Care Board
2. The Better Care Plan has been reviewed by all providers and VCS and their feedback incorporated into the final plan.
3. The schemes will be monitored closely to ensure they deliver the expected outcomes and benefits, with monthly report on progress to the Better care Board.

11. **Communication**
There is a risk that the communication of the programme is not handled correctly and that this undermines the programme with internal and external stakeholders

| 3 | 3 | 9 |

1. A communications and engagement strategy has been developed to coordinate communications with all the schemes
2. This is discussed at the monthly Better Care Board meetings.
3. A joint post has been agreed to focus exclusively on the communications for the programme from September 2014.

**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 BCF is viewed in the City as part of a whole systems approach to health and social care integration, including our plans to implement the Care Act. The plans in our BCF submission align to a number of initiatives related to care and support.

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 be aware of their key deliverables.
The Care Act places significant new duties upon Councils and a dedicated programme is in place to implement these duties. The programme is overseen by the Modernisation Board in Adult Social Care and this Board is closely aligned with the Better Care Programme Board. There is senior officer representation from the Council and CCG on both Boards and the two programmes share a range of enabling work streams including communication, finance, performance, ICT and workforce. A dedicated programme plan is in place and within this a range of specific themed projects (schemes) focused on delivering the requirements of the Care Act. This is linked to an analysis of the ‘gap’ between current policy and practice and the requirements of the Act.

The EPIC pilot is in response to a successful bid for the Prime Minister’s Challenge Fund. It is GP led and supported by Brighton Integrated Care Services (BICS). EPIC delivers extended access by rethinking how General Practice delivers all of its functions by

- changing the skill mix to meet patients’ needs
- increasing access points
- creating shared patient record
- reconnecting General Practice to local community assets.

This pilot pump-primes this transformation providing safe “same day access” and freeing GPs to focus on more patients with complex need. Although not commissioned by the CCG, EPIC ties in with all the work we are doing to support people with long-term and complex conditions outside of hospital and in the community. This project links to the Better Care programme through the Frailty Programme with the learning from EPiC informing the development of the model of care in Phase 1. The Clinical Director for EPiC is a member of the Better Care Board.

The Systems Resilience Group (SRG), formerly the Urgent Care Working Group, encompasses the Brighton and Sussex University Hospitals Trust local health catchment area and has oversight capacity plans in the system. The SRG has recently revised its ToR and has responsibility for signing off the Operational Resilience Capacity Plan and use of money. There is significant crossover with initiatives in both the SRG and the Better Care Programme and we have ensured that there is one single view of the investment for both the Better care and SRG programmes to ensure that the outcomes in both are realised.
The Boards of both the SRG and the Better Care Programme are currently being aligned to ensure both are delivered effectively and efficiently.

The Health and Wellbeing Board’s primary duties are to:

- Agree the local Joint Health & Wellbeing Strategy for Brighton and Hove, setting out the HWB’s health and social care priorities for the city
- Publishing the local Joint Strategic Needs Assessment, setting out local health and social care requirements and assets
- Promoting co-working across local health and social care services
- Ensuring that health and social care commissioning is based on local needs
- Ensuring that local people are encouraged to take a full part in decision-making about local services.

The Better Care programme is integral to delivering the Health and Wellbeing strategy and will report progress to the Health and Wellbeing Board. The plan has been approved by the HWB Board. The diagram below illustrates these interdependencies.

![Diagram of Health and Wellbeing Strategy](image)

**Figure 18: How the Better Care Programme and dependencies align to the HWB Strategy**

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*
 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.

General practice are at the heart of our Better Care Plan and our Strategic Commission Plan and out local primary care leads in the City have been involved at every stage of the development of this plan see section 8b)

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 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;
- 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 £5.96m 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, wellbeing 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;
- 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
- Integrated community equipment service open 6 days a week

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. Our intention is to expand the tool 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
We are undertaking a baseline data collection in Q3 to ascertain how many high risk people have care plans in place currently.

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

From its inception user involvement has therefore been core to the programme as a whole and to each strand of the programme, for example the voluntary sector is represented on the Better Care Board.

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.

Frontline 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 Managers were fully involved in the Frailty Event in July 2014, attached at section 1c.

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.
ANNEX 1 – Detailed Scheme Description –
For more detail on how to complete this template, please refer to the Technical Guidance

<table>
<thead>
<tr>
<th>Scheme ref no.</th>
<th>1</th>
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<tbody>
<tr>
<td>Scheme name</td>
<td>7 Day Working</td>
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**7 Day Working**

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

**What is the strategic objective of this scheme?**

The strategic objective of 7 day a week working is to ensure timely transfer from an acute setting. It will ensure that a similar service is provided to users regardless of when they are able to move on from the acute setting. It will help ensure resources are used to best effect i.e. in the community when the user no longer requires care in a hospital setting.

**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?

We will build on our 7 day working by investing in a range of service developments across hospital and out of hospital care. We will increase 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). We will also work with the acute trust to ensure consistent 7 day working within the hospital and enable timely discharge across the entire week. We will build on our hospital and community social work service and on the infrastructure to support out of hours services. We will work with care home & home care providers to ensure a timely 7 day response to requests for services. ASC will commission a standby home care service from one home care provider to take referrals over 7 days per week. This will involve having a care co-ordinator/supervisor available on Saturday and Sunday to take referrals and allocate to care workers as well as two care workers on call to take the work.

Care homes will be commissioned to facilitate hospital discharge in a timely way throughout the 7 day week. They will undertake assessments and work with wider services to make the appropriate arrangements to ensure a person’s move to a care home is not delayed.

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners: Debbie Greening ASC - The Home Care contract is monitored by ASC contract officers, additional performance metrics will be collected to demonstrate uptake of care packages to start out of normal hours.

Commissioners: Jane MacDonald ASC Care Home contracts are monitored by ASC contract officers, additional performance metrics will be collected to demonstrate additional activity from providers. (Note the above activity will require input from CCG Commissioners and is likely to be jointly commissioned)

Providers: Sussex Partnership Trust

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**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

Previous on-call arrangements over bank holiday periods have allowed us to test this model. It is an affordable solution as all home care providers working on the Council contract work 7 days per week already so the additional cost is to ensure they have someone to take referrals and co-ordinate the care and also available care workers to pick up referrals at short notice. The care provider will also be paid the usual hourly rate for providing the care.

Currently people could be discharged to care homes more effectively at weekends. Providers will be commissioned to support the wider services make timely discharges. There is evidence that people who are ready to move to care homes stay longer than is necessary in acute settings. This is neither good for them or for the wider system. 7 day a week care homes input is key to ensure discharge pathways function well.

**Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15 £637k recurring
2015/16 £800k recurring

**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

This scheme is expected to reduce emergency admissions by 80 in 2015/16. This has been calculated based on the additional community capacity we are commissioning and applying a conversion rate – this is different for each service for example we know that for CRRS most contacts result in an avoided admission but extended GP hours are likely to reduce A&E attendances more than emergency admissions. The metrics we plan to monitor for this scheme are contained at the end of this Annex.

**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?

Each scheme will be monitored through the PMO, with monthly reporting via a KPI dashboard reported to the relevant Board to ensure the scheme is on track to meet its targets. In this case the scheme will be reported to the System Resilience Group, monitor the progress of the scheme and suggest remedial action if necessary.

**What are the key success factors for implementation of this scheme?**

- Additional therapist in STS
- CareLink in place
- Extension for ICES
- Additional Care Managers working across the City localities 7 days per week
Support our frail and vulnerable 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 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.

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?

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 are testing out frailty teams with two clusters of GP practices and prior to full city roll out we will strengthen the existing primary care and community services across the City. 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 (equivalent to £1.5m for the City) and roll out a Locally Commissioned Service for patients 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 DES.

To complement the development of the locally commissioned service 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.

The cohort of people for this scheme are over 75s, high risk of hospital admission, Housebound patients, under 75s with LTC or at risk of admission to hospital.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner: Brighton and Hove CCG and BHCC

Providers:
- General Practice
- Sussex Community Trust
- Sussex Partnership Foundation Trust
- Community Short Term Services
- BHCC
- Age UK

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

Care co-ordination is a person-centred, pro-active approach to bringing health and social care services together around the needs of service users. It involves assessment of an individual’s needs, development of a comprehensive care plan and a designated care co-ordinator to manage and monitor services around the individual, recognised in recent changes to the GP contract.

Key pointers from evidence include:
- a holistic focus that supports service users to manage their own conditions at home and become more independent and resilient rather than a purely clinical focus on treating medical conditions
- a single entry point for care co-ordinators to provide personal continuity for patients and carers as well as enabling access to care through multidisciplinary teams
- shared electronic health records can support the process but a ‘high-touch, low-tech’ approach can promote face-to-face communication, foster collaboration and enable meaningful conversations about care for patients with complex needs
- co-ordinating care at the neighbourhood level ‘where the benefits of engagement with local communities sit alongside the need to have close working relationships within multi-disciplinary teams dealing with manageable caseloads’
- prioritising engagement with GPs and links with secondary care to ensure quality transitions, for example, from hospital to home.

(Goodwin et al 2013)

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). 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). Evidence suggests that a significant proportion of admissions could be avoided if alternative forms of care were available (Health Foundation 2013).

It is estimated that between 40-50% of admissions to the acute organic assessment ward are from care homes and there will be % of admissions to BSUH. The 2 RMNS nurses will work closely and proactively with patients that are experiencing challenging behaviours related to dementia, on the verge of admission to hospital or needing to step up the care home pathway. It is also anticipated that the role will work alongside care homes at the assessment process whilst in hospital to facilitate discharge, prevent further moves, support placements to accept more challenging patients, offer bespoke support after discharge and aim to return patients to the existing care home. With intensive, proactive support prior to admission offering more than pharmacological intervention I think we would be able to prevent some admissions but also facilitate care homes accepting people back.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15 £1,235m funding to strengthen existing services
2015/16 £1,693m funding to strengthen existing services

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

61
headline metrics below

The proactive care projects will reduce emergency admissions by targeting those most at risk of hospital admission and proactively managing their care. Based on Capita research conducted for the CCG admissions are likely to reduce, by one a year, for the cohort of moderately frail patients. This equates to approximately 203 admissions in 2014/15 and 545 in 2015/16. The metrics we plan to monitor for this scheme are contained at the end of this Annex.

During 2014/15 we are also undertaking a new data collection to provide a baseline for future service developments. The new data items are as follows:

- No. of patients on frailty register
- No. of patients on register with a completed pre-assessment
- No. of patients on register with frailty score
- No. of patients on register who have had a care and support assessment
- No. of patients on register who have had a preventative assessment
- No. of patients on register who have had a home consultation
- No. of practice appointments available
- No. of practice appointments attended
- No. of practice same day appointments available
- No. of practice same day appointments attended
- Primary care frequent flyers

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?

Each scheme will be monitored through the PMO, with monthly reporting via a KPI dashboard reported to the relevant Board to ensure the scheme is on track to meet its targets. In this case the scheme will be reported to the Proactive Care Project Board, monitor the progress of the scheme and suggest remedial action if necessary. The Board established in August 2014 to oversee delivery of the proactive care programme and is accountable to practices and the CCG via the Clinical Strategy Group. The Better Care Board has members in common with the Proactive Care Board and are presented with monthly updates.

What are the key success factors for implementation of this scheme?

- Strengthen existing services
- Develop Primary Care Proactive Care model
- Implement Primary Care Proactive Care model
- Evaluate impact of proactive care programme
- Review the role of the SW in the IPCT’s and agree additional services to be evaluated
What is the strategic objective of this scheme?

For citizens admitted to hospital our ambition is for the system to support them to recover and return home as soon as they are ready. Community and hospital teams will work together with the patient to plan on-going care and ensure discharge home in a timely way, reducing length of stay in hospital and delayed transfers of care.

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?

This programme of work is about reducing 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 patients 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 patients 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 patient flow in the hospital and reduce delayed transfers of care.

We will increase capacity in a range of community services and develop in-reach models of care in order to maintain and promote independence for people requiring a hospital admission.

Cohort: Any person admitted to, or who attends hospital.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner: Brighton and Hove CCG and BHCC

Providers:
- General Practice
- Sussex Community Trust
- Sussex Partnership Foundation Trust
- Community Short Term Services
- BHCC
- Age UK

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

Eighty per cent of emergency admissions whose length of stay exceeds two weeks are aged over 65. Poteliakhoff and Thompson (2011) suggest that focusing on reducing length of stay for older
people may have the most potential for reducing use and cost of hospital beds. If all areas achieved the rate of admission and average length of stay of those in the lowest 25th percentile, 7,000 fewer hospital beds would be needed across England (Imison et al 2012).

NHS and social care should work together to provide good discharge planning and post-discharge support. A structured individualised discharge plan can reduce readmissions by around 15 per cent (Shepperd et al 2010). Early supported discharge has been shown to enable people to return home earlier, remain at home in the long term and regain their independence in activities of daily living. (Fearon and Langhorne 2005).

<table>
<thead>
<tr>
<th>Investment requirements</th>
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<tbody>
<tr>
<td>Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan</td>
</tr>
<tr>
<td>2014/15 £1.052m recurrent funding to strengthen existing services</td>
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<tr>
<td>2015/16 £2,875m recurrent funding to strengthen existing services</td>
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<tr>
<th>Impact of scheme</th>
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<tr>
<td>Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan</td>
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<tr>
<td>Please provide any further information about anticipated outcomes that is not captured in headline metrics below</td>
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<tr>
<td>This scheme will reduce the length of stay for patients who have been admitted to hospital as an emergency, we estimate that 540 beddays can be saved per year. Part of this will be to reduce delayed transfers of care by 320 days this year and a further 284 in 2015/16.</td>
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<tr>
<td>We also envisage that this scheme will reduce readmissions to hospital and increase the number of people discharged to their usual place of residence. The metrics we plan to monitor for this scheme are contained at the end of this Annex.</td>
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<table>
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<th>Feedback loop</th>
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<tr>
<th>What are the key success factors for implementation of this scheme?</th>
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<tr>
<td>• Internal frailty pathway - service commencement</td>
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<tr>
<td>• Dedicated ambulance - service commencement</td>
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<tr>
<td>• Additional STS capacity - in place</td>
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<tr>
<td>• Decision to admit pilot commencement</td>
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<tr>
<td>• Interim beds commencement</td>
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<tr>
<td>• Inreach frailty coordinator in place</td>
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<tr>
<td>• Additional CRRS capacity in place</td>
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<td>• Additional homecare capacity in place</td>
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</table>
What is the strategic objective of this scheme?

The Care Act places significant new duties upon Councils and a dedicated programme is in place to implement these duties. The programme is overseen by the Modernisation Board in Adult Social Care and this Board is closely aligned with the Better Care Programme Board. There is senior officer representation from the Council and CCG on both Boards and the two programmes share a range of enabling work streams including communication, finance, performance, ICT and workforce. A dedicated programme plan is in place and within this a range of specific themed projects (schemes) focused on delivering the requirements of the Care Act. This is linked to an analysis of the ‘gap’ between current policy and practice and the requirements of the Act.

It was within this context that the Protection of Adult Care in relation to the Care Act within the Better Care fund needs to be considered. Some of the key pressures identified in the implementation planning are:

- 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 and this needs to done in partnership
- There will be a need for significant systems and workforce development
- Councils will have statutory duties re market development and market failure and the provision of preventive services.

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?

Some aspects of the Care Act implementation such as Information & Advice, carers and assessments / care planning are aligned to key aspects of the Better Care programme and we are seeking to ensure that where appropriate the two programmes work in harmony. 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.

Cohort: 5,000 citizens who are eligible and access social care services

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner: Brighton and Hove CCG and BHCC
Provider: Sussex Community Trust

**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

Gap analysis by lead officers of current policy and practice against requirements of Care Act. This cannot be completed until the final regulations and guidance is in place.

Use of national and regional networks to draw on best practice and investigate shared solutions / learning.

- Use of national modelling tools such as the Lincolnshire Model and the IPC Toolkit.
- Initiation of BPR project of the assessment /review/care planning process.
- Analysis of user / carer engagement and feedback.
- Analysis of performance data.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£3,275 in 2014/15
£5,958 in 2015/16

**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

The metrics we plan to monitor for this scheme are contained at the end of this Annex.

**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?

There is a dedicated Programme in place to implement the Care Act supported by Governance arrangements, a Programme manager and a full set of documentation covering the whole
programme and each project / scheme within this. This will include any delivery chain where needed.

Brighton and Hove County Council lead for Care Link monitoring centre for telecare. The system also has Telehealth capabilities.

Sussex Community Trust and GP practices will engage in any Telehealth programmes.

What are the key success factors for implementation of this scheme?

- 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
- Further investment in advocacy services in response to the Care Act requirements from April 2015
- Development of better information signposting & advice services
### Scheme ref no.
5

### Scheme name
Supporting Carers

### What is the strategic objective of this scheme?
Brighton & Hove has a Multi-Agency Carers Commissioning Strategy across Adult Social Care, the Clinical Commissioning Group, and the Voluntary Sector. The strategy reflects the five outcomes of the National Carers Strategy focusing on:

- Identification and recognition of carers
- Realising and releasing potential of carers
- A life outside of caring for carers
- Supporting carers to stay healthy
- Young carers

A diverse range of services directly relating to the above outcomes have been jointly commissioned by ASC and the CCG. These include both voluntary and statutory provision aimed at supporting carers within the City.

Our Strategy is currently under review and will be developed to reflect, not only the national Carers Strategy Outcomes, but also key drivers for supporting carers to remain healthy and to increase their well-being, including:

- The Care and Support Act – focus on carers and their well-being; and new statutory duties for supporting carers
- Key Indicators within the ASC and NHS Outcomes Framework – enhancing the quality of life for carers; and improving the satisfaction of carers regarding social services
- Local Carers Action Plan (from the annual Carers Survey) – focusing on increased access to information and advice; reducing social isolation; and improving respite services.
- Better Care – greater integration between health and social care services, and better recognition of carers.
- Currently we have a working document to support the development of a Carers Strategy for 2015 – the Carers Vision, promoting 6 objectives:
  - Increased Carers Awareness – through the Carers Charter; Carers Register; and Carers Card.
  - Strong infrastructure to support adult, parent and young carers – the Carers Partnership
  - Tiered approach to supporting carers – from preventative services, to Carers Register, to complex statutory interventions.
  - Embrace a Whole Family Approach to supporting carers.
  - Greater integrated working between ASC; the NHS; and the voluntary sector, building on the Carers Support Service within the Integrated Primary Care Teams.
  - Develop the Carers Card as a key vehicle to promote carer awareness and supporting carers.

### 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?

Brighton and Hove provide a range of services to support carers (informal unpaid carers), from
information; advice; support; engagement; assessment; specialist training opportunities; and home-based respite services. Additionally the Self Directed Support Carers Budget enables carers who have had an assessment of their needs to apply for funding for bespoke support and breaks, from funding towards a holiday to driving lessons. Providing carers with breaks is key to supporting their needs from holidays to regular activities, and providing support to enable them to attend health appointments through the Carers Prescription Scheme.

The new Carers Reablement Project will support carers, assisted by volunteers, to achieve positive changes within their lives. Through a goals approach to reaching clearly defined outcomes. These outcomes will aim to improve the health and well-being of the carer.

The Outcomes a carer may wish to achieve will be individual to that carer, but could include:

- Attending a support group, or activity group
- Joining a gym
- Learning to cook
- Regaining previous skills related to returning to work.

Additionally, this project will raise the profile of carers and work with all relevant agencies to ensure they are “thinking carer” – NHS, ASC, Independent Providers and the Voluntary Sector. Linking with the initiative of the Carers Card – local discount card for carers.

Cohort: Census 2011 data – 9% of the population of Brighton and Hove are carers, 23,967 people – including adult, parent and young carers.

### The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Joint CCG and ASC Carers Commissioning Manager, commissioned the service with a draft Service Specification. The Carers Centre Brighton and Hove is the successful provider, the service specification and key performance indicators have been agreed. The ASC Contracts Unit will monitor the quarterly data, and arrange bi-annual contract reviews.

Providers: Carers Centre, Alzheimer's Society, PATCHED (CRI), AMAZE, CROSSROADS, Sussex Community Trust

### 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

Supporting carers is a key national and local priority, we know carers save both the NHS and ASC billions of pounds per year, and provide a genuinely bespoke service for so many people. If carers are not effectively supported then individuals are put at risk, and additionally resources will need to be funded.

Brighton and Hove has a range of mechanisms for ongoing dialogue with carers, to ensure their views are being heard and that services are supporting them effectively, these include:

- Carers Forum
- Annual ASC Carers Survey
- Multi-Agency Carers Strategy Group
- Carers Register
- Carers Partnership – key carers’ organisations, NHS and ASC regular strategic and operational discussions.

National and Regional resources such as the Carers Hub, provides a range of national evidence and best practice and it is clear that there are issues related to carers “not looking after
themselves” and needing the encouragement/support of others to ensure their well-being needs are being met. Brighton and Hove has a proven track record for supporting and utilising the skills of volunteers in a range of settings, and we will be drawing on that to support the Carers Reablement Project. Many former carers have also identified that they would like to access volunteering opportunities, and this would be an interesting element to the project.

Recent reports from both Carers UK (State of Caring 2014) and the LSE has addressed the need to support carers to balance being able to work and continue to care, in order to support the national economy. An element of this project will relate to supporting carers back into the workplace, if they have defined that as a desired outcome. The project will be using the Carers Outcome Star, developed by Carers UK, to evaluate the impact of the project on individual carers. This evaluation tool is being widely recognised as best practice for carers services.

Additionally we developing locally a mechanisms to capture “cost avoidance” evidence, where interventions to support carers have avoided the cost of – residential placements; nursing placements; urgent homecare packages; acute admissions; and mental health acute admissions. We will explore whether this project can support this evidence base.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15 £602k
2015/16 £891k

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

Through delivery of this project we hope to undertake needs assessments for all carers, in 2014/15 we hope to undertake 45% of the assessments. We also hope to improve the lives of carers by increasing the number of carers accessing breaks and those reporting a positive outcome from the Carers Reablement Project..

The metrics we plan to monitor for this scheme are contained at the end of this Annex.

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?

Each scheme will be monitored through the PMO, with monthly reporting via a KPI dashboard reported to the relevant Board to ensure the scheme is on track to meet its targets. In this case the scheme will be reported to the Multi-Agency Carers Strategy Group, monitor the progress of the scheme and suggest remedial action if necessary. Performance will be monitored via ASC Performance and Development Team Quarterly Performance data reports; Contracted Services Performance data (quarterly and bi-annually) collated by the ASC Contracts Unit; Carers Update reports presented by the Carers Commissioner to the ASC Senior Departmental Managers Team; and the Carers Strategy Group.

What are the key success factors for implementation of this scheme?

- Annual ASC Carers Survey
- Multi-Agency Carers Strategy Group
- Carers Register
- Carers Partnership – key carers organisations, NHS and ASC regular strategic and operational discussions.
**Scheme ref no.**
6

**Scheme name**
Keeping People Well

**What is the strategic objective of this scheme?**

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.

**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 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.

<table>
<thead>
<tr>
<th>The delivery chain</th>
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<tbody>
<tr>
<td>Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</td>
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<tr>
<td>Commissioner:</td>
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<tr>
<td>Brighton and Hove CCG and BHCC</td>
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<tr>
<th>The evidence base</th>
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<tbody>
<tr>
<td>Please reference the evidence base which you have drawn on</td>
</tr>
<tr>
<td>- to support the selection and design of this scheme</td>
</tr>
<tr>
<td>- to drive assumptions about impact and outcomes</td>
</tr>
<tr>
<td>National evidence on importance of good quality and reliable information on health conditions, services and wider sources of support (e.g. Patient Information Forum, <a href="http://www.pifonline.org.uk/wp-content/uploads/2013/05/PiF-full-report-FINAL-new.pdf">http://www.pifonline.org.uk/wp-content/uploads/2013/05/PiF-full-report-FINAL-new.pdf</a>)</td>
</tr>
<tr>
<td>Local research indicating that patients/carers need a “one stop shop” with accurate and reliable information on health and related services (Brighton &amp; Hove CCG Patient and Public Participation Strategy consultation August 2014)</td>
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<tr>
<th>Investment requirements</th>
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<tbody>
<tr>
<td>Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan</td>
</tr>
<tr>
<td>2014/15 £400k</td>
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<td>2015/16 £450k</td>
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<tr>
<th>Impact of scheme</th>
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<tr>
<td>Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan</td>
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<tr>
<td>Please provide any further information about anticipated outcomes that is not captured in headline metrics below</td>
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<tr>
<td>The metrics we plan to monitor for this scheme are contained at the end of this Annex.</td>
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<tr>
<th>Feedback loop</th>
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<tr>
<td>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?</td>
</tr>
<tr>
<td>Each scheme will be monitored through the PMO, with monthly reporting via a KPI dashboard reported to the relevant Board to ensure the scheme is on track to meet its targets. In this case the scheme will be reported to the Information Prescription Steering Group, monitor the progress of the scheme and suggest remedial action if necessary.</td>
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<table>
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<tr>
<th>What are the key success factors for implementation of this scheme?</th>
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<tbody>
<tr>
<td>• Work with the community &amp; voluntary sector to proactively support them to attract and alternative funding opportunities</td>
</tr>
<tr>
<td>• Develop better information signposting &amp; advice services</td>
</tr>
<tr>
<td>• Launch online portal</td>
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</table>
What is the strategic objective of this scheme?

Support our frail and vulnerable 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 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.

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?

In 2014-15 we will test out during Phase 1 of our plans the development of integrated multi-disciplinary teams based around two clusters of GP practices. One cluster comprises three practices in Hove with a combined list size of 22,000. The second cluster comprises two practices in Central Brighton with combined list sizes of 24,000. 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.

We will test out the model during Phase 1 of our plans at a relatively small scale with the two clusters of practices and ensure lessons learned inform the full roll out across the whole city in 2016/17. Phase 1 will start in October 2014 and a detailed evaluation will take place after six months. The evaluation stage will last three months and take into account learning from all parts of the system to inform and shape the future model. It is proposed that the full roll out of the new model will commence in 2016/17. It is at this point that the full benefits of the better care programme will begin to be realised. By the end of 2016/17 we hope to have a fully integrated model of care for frail and vulnerable people that support them to remain independent and provide responsive services 7 days a week.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner: Brighton and Hove CCG & BHCC

Providers:
5 General Practices, Voluntary Sector Sussex Community NHS Trust, Sussex Partnership Foundation Trust, Brighton and Sussex University Hospital Trust, Brighton Integrated Care Service, Independent Sector

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

Integrating primary and social care has been shown to reduce admissions, and integration of
primary and secondary care for disease management of patients with certain conditions has been shown to reduce unplanned admissions (Curry and Ham 2010).

In Torbay, which has developed an integrated health and social care economy, they were able to reduce the number of delayed transfers of care from hospital to a negligible number, reduce emergency bed day use for people aged 85 and over by 32 per cent between 2003 and 2008 and reduce emergency bed day use for people aged over 65 to the lowest in the region, at 1920 per 1000 population compared to an average of 2698 per population in 2009/10 (Thistlethwaite 2011). One of the consequences was that average daily bed day use in Torbay fell from 750 beds in 1998/99 to 502 beds in 2009/10. (Thistlethwaite 2011).

### Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>2014/15</td>
<td>£321k</td>
</tr>
<tr>
<td>2015/16</td>
<td>£400k</td>
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</tbody>
</table>

### 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

The metrics we plan to monitor for this scheme are contained at the end of this Annex.

### 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?

Each scheme will be monitored through the PMO, with monthly reporting via a KPI dashboard reported to the relevant Board to ensure the scheme is on track to meet its targets. In this case the scheme will be reported to the Implementation Board, monitor the progress of the scheme and suggest remedial action if necessary. The Implementation Board is directly accountable to the Better Care Board. Monthly updates are a standing item on the Better Care Board agenda.

### What are the key success factors for implementation of this scheme?

- Development of Phase One frailty model: clinical pathways, thresholds and processes & care plans, governance and quality
- Integrated informatics solutions
- Shared patient information and care plans
- Cross organisational working
**Integrated Homeless Model**

**What is the strategic objective of this scheme?**

We aim to develop integrated seamless flexible care pathways cutting across service boundaries improving health outcomes and increasing access to healthcare for the homeless.

**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?

Brighton & Hove will introduce a person centred model specific to the needs of homeless people in the City. The homeless population are some of our most vulnerable individuals, often with a combination of physical ill-health with mental illness and substance misuse (drug and alcohol), complex health needs and premature death. The City is seeing a year on year rise in homelessness. Homeless people are more likely to use A&E, spend time in hospital and be heavy users of mental health and substance misuse services.

We aim to develop integrated seamless flexible care pathways cutting across service boundaries improving health outcomes and increasing access to healthcare. A multi-disciplinary integrated support team will be co-ordinated within the setting of the city centre integrating pathways into and out of other key service areas and implementing integrated core solutions for key areas.

We would embed evidence based practice and personalisation in all areas of service delivery sharing the learning locally and nationally.

Cohort: Quantifying the local Homeless population is challenging due to the transient nature of the population cohort, local data can change on almost a daily basis. During 14/15 improved identification of the homeless population and development of baseline data to eliminate any double counting is a priority. Whilst it is difficult to precisely quantify the homeless number, the following Venn diagram illustrates the cohorts of a number of homeless categories in Brighton and Hove.

![Venn diagram](image-url)
Our objective is to reduce NEL admissions and A&E attendances for the homeless who are engaged with the 2 Homeless projects Pathway Plus and the Hostels Collaborative project.

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

<table>
<thead>
<tr>
<th>Commissioner:</th>
<th>Brighton and Hove CCG &amp; BHCC</th>
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</thead>
<tbody>
<tr>
<td>Providers:</td>
<td>Morley Street Practice, Sussex Community Trust, BSUH, SPFT, Brighton Housing Trust, Just Life Foundation, St Johns Ambulance, General Practice</td>
</tr>
</tbody>
</table>

**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

**Pilots (4 parts of the country)**

A pilot offering integrated care for homeless people with the aim of reducing mortality and morbidity, and reducing acute secondary healthcare usage among its clients. Using a band 7 nurse, care coordinator and GP (once a week) reductions seen in secondary care usage.

Multiple exclusion homelessness. Access to assessment is the key to accessing the resources that allow for outcome based and individualised responses. More importantly, access to a shared or common assessment framework is vital if we are to prevent a 'retrench to silos' where each service sector evolves its own approach to personalisation meaning that people end up with multiple budgets, one for health, one for care and one for housing support.

Hospitals, local authority housing teams and voluntary sector organisations should work together to agree a clear process from admission through to discharge to ensure homeless patients are discharged with somewhere to go and with support in place for their on-going care. This process should start on admission to hospital.

The psychologically informed environment (PIE) can be created in a service such as a hostel or day centre where the social environment makes people feel emotionally safe. A PIE is an approach rather than a place; it’s an ‘enabling environment’. PIEs can be developed within existing commissioned services, wherever appropriate training and development enables staff to respond effectively to people with psychological needs and longstanding emotional problems.

"Role for adult social care for the homeless
  · Improved communication between ASC and hostel staff
  · Better understanding of role and remit of ASC for hostel staff
  · Continuity resulting in a more joined up way of working and better outcomes for clients
  · Proactive working leading to early interventions for clients"

"Peer support for homeless toolkit and Promoting Access to Health Services (PATHS) project

Toolkit- Peer support for homeless this includes peer health education, Peer health promotion,
peer health advocacy, peer involvement in commissioning.

The PATHS project provides volunteers who can go with patients to their appointments, helping them to remember the time and day, find the their way there and back, and to feel confident enough to deal with new health staff"

Pathways - Standard for commissioners and service providers- Faculty of homeless health.

"Service user involvement, engagement and empowerment

Person centred coordinated care where by the individuals needs are fully assessed and are given timely readily understood information and are supported to make informed choices and to be actively involved in their care planning to help them to reach their goals and desired outcomes. They will have coordinated MDT care that will support them in making decisions about their care and the personal health/social care budgets available to them to obtain their goals. Ensuring a smooth transition into other services once outcomes have been realised."


http://www.mungos.org/services/recovery_from_homelessness/homeless_intermediate_care_pilot_project/


Pathway at BSUH (2011)


http://homeless.org.uk/ASC-specialist-social-work-post-hostel-residents

http://homeless.org.uk/sites/default/files/HomelessHealth_PeerActivityToolkit_0.pdf

http://www.oxhop.org.uk/getinvolved/paths.html


Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15 Existing funding of £587k from non BCF funds
2015/16 £587 recurring funds

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
The overarching impact on quality would be REDUCED UTILISATION OF UNPLANNED HEALTHCARE, increased ACCESS TO HEALTH CARE (For example, improvements in registration with a dentist (from 38%)), and improved access to mainstream community health and social care services, and client experiences.

In 2014/15 a baseline data collection is being undertaken to ensure that we fully capture this cohort of people.

The metrics we plan to monitor for this scheme are contained at the end of this Annex.

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?

Each scheme will be monitored through the PMO, with monthly reporting via a KPI dashboard reported to the relevant Board to ensure the scheme is on track to meet its targets. In this case the scheme will be reported to the Implementation Board, monitor the progress of the scheme and suggest remedial action if necessary. The Implementation Board is directly accountable to the Better Care Board. Monthly updates are a standing item on the Better Care Board agenda.

What are the key success factors for implementation of this scheme?

- Interim projects evaluation (6 months)
- Development of integrated homeless hub and spoke model including governance quality, KPI's
- Evaluation of learning from homeless joint working projects
- Business Case for Homeless Model approved
- Mobilisation plans
- Homeless Hub and Spoke Model
**Scheme ref no.**
9

**Scheme name**

**Dementia**

**What is the strategic objective of this scheme?**

Dementia is both complex and common, and it requires joint working across many sectors. Timely diagnosis is the key to improving quality of life for people with dementia and their carers. Dementia is a life limiting illness and people can live up to 12 years after diagnosis with increasing disability and need for support. There is evidence that people with dementia have worse clinical outcomes than people with the same conditions without dementia. However, there is also evidence that early information, support and advice at the point of diagnosis enables people to remain independent and in their own homes for longer. This scheme fits well with the Brighton and Hove Better care vision and is a key element of the Joint Health And Wellbeing strategy.

**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?

It is anticipated that one of the key groups of people that will benefit from the new MDT approach outlined as part of our Frailty plans will be people with dementia and their carers*. Less than 40% 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 in 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. We recognise that some care and support would be better provided at a City wide level rather than an MDT level (for example information and advice or more specialist services) and our plans are for the MDT’s to be supported by Dementia Hubs. 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 care, support and information to people with dementia and address gaps in care pathways in line with the recommendations of the 2014 Dementia JSNA. Examples include the development of a single information point, establish a Dementia Action Alliance to lead and co-ordinate the development of dementia friendly initiatives, including public education campaigns and improving the support available to primary care.

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner: Brighton and Hove CCG and BHCC

Providers: Primary Care, Memory Assessment Service, Community and Voluntary Sector, Adult Social Care, SCT, SPFT
The evidence base

Dementia affects a large proportion of people and the numbers are increasing as the population is ageing. It places pressure on all aspects of the health and social care system: An estimated 25% of hospital beds are occupied by people with dementia, who have longer lengths of stay, and more readmissions. Approximately two-thirds of care home residents are estimated to have dementia and one in three people will care for someone with dementia in their lifetime (1) There is a range of evidence to support the development of dementia services. The NICE commissioning guide [CMG48] for dementia summarises the key commissioning issues and the resource impact from implementing the recommendations in NICE guidance to support improvements in the quality of care for people with dementia. Recommendations are for a whole system approach to commissioning and increased investment in the identification of people with dementia to enable greater numbers of people to be diagnosed with dementia. This provides an opportunity to provide support at an earlier stage to enable people and their carers to live well with dementia. There is evidence that investing in this care and support can help prevent crises, avoid unnecessary hospital admissions and reduce the avoidable use of residential care.

(2) NICE Commissioning Guidance for Dementia http://www.nice.org.uk/guidance/CMG48/chapter/executive-summary

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15 40k
2015/16 250k

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

The metrics we plan to monitor for this scheme are contained at the end of this Annex.

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?

Each scheme will be monitored through the PMO, with monthly reporting via a KPI dashboard reported to the relevant Board to ensure the scheme is on track to meet its targets. In this case the scheme will be reported to the Dementia Partnership Group, monitor the progress of the scheme and suggest remedial action if necessary. The Dementia Partnership Group is directly accountable to the Health and Wellbeing Board.

What are the key success factors for implementation of this scheme?

- 2014-2017 Dementia Plan approved by Health and Wellbeing Board
- Primary Care Support launched to improve dementia diagnosis rate
- Dementia Diagnosis Rate of 67% is achieved
What is the strategic objective of this scheme?

The project contributes to the following system objectives of the CCG 14-16 Operating Plan; 1. Align our commissioning to the health needs of our population and ensure we are addressing health inequalities across the city. 2. Increase capacity and capability in primary and community services to focus on preventative and proactive care - particularly for the most frail and disadvantaged communities. The project also supports NHS Outcomes Framework 14/15 Domain 2: Enhancing the Quality of life for people with long-term conditions.

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?

PHBs are a key aspect of personalisation - with the aim of improving patient outcomes by placing patients 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, patients 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 patients 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.

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

National Evaluation of 64 PHB pilots undertaken by University of Kent/London School of Economics and Political Science. The evaluation report (Nov 12) noted' the use of personal health budgets was associated with a significant improvement in the care-related quality of life and psychological wellbeing of patients'. In addition the evaluation noted a marked decrease in the use of primary and acute care services was found among the continuing healthcare and mental health PHB cohorts. Potential cost efficiencies among these two groups were considered significant. In July 14 NHSE announced the Integrated Personalised Commissioning Programme for CCGs and local authorities to pilot integrated personal budgets from 2015-16 in a number of areas including long term conditions/frailty and children with complex needs.

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

Through delivery of this programme in 2014/15 we hope to increase the number of CHC patients (adult and children) with personal Health Budgets.

In 2015/16 we will extend the offer to the frail and vulnerable population.

The metrics we plan to monitor for this scheme are contained at the end of this Annex.

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?

Each scheme will be monitored through the PMO, with monthly reporting via a KPI dashboard reported to the relevant Board to ensure the scheme is on track to meet its targets. In this case the scheme will be reported to the PHB Reference Group, monitor the progress of the scheme and suggest remedial action if necessary. The PHB Reference Group is directly accountable to the Better Care Board.

What are the key success factors for implementation of this scheme?

- Arrangements/Processes established to provide PHBs to all CHC patients who wish to receive them
- Agree extension of PHB project into Better Care Frailty (Phase 1)/Homeless projects
- Agree arrangements for managing/monitoring PHBs for children with Complex Needs
- Application to participate in Integrated Personalised Commissioning Programme -
- Collate/Evaluate learning from 14-15 project to inform extension of PHBs in 15-16
## Annex 1 – Supporting KPIs

<table>
<thead>
<tr>
<th>Pay for Performance</th>
<th>Source</th>
<th>Methodology</th>
<th>Frequency</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline</th>
<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Total non-elective admissions in to hospital (general &amp; acute), all-age</td>
<td>MAR</td>
<td>Apportioned for B&amp;H residents in any CCG</td>
<td>Quarterly</td>
<td>-</td>
<td>-</td>
<td>26,133</td>
<td>2014</td>
</tr>
<tr>
<td>Supporting Metrics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population</td>
<td>HSCIC and ONS</td>
<td>2013/14 admissions against 2012 mid-year population</td>
<td>Annually</td>
<td>270</td>
<td>36,605</td>
<td>734.9</td>
<td>2013/14</td>
</tr>
<tr>
<td>1.3 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</td>
<td>HSCIC</td>
<td>2013/14 discharges</td>
<td>Annually</td>
<td>265</td>
<td>330</td>
<td>80%</td>
<td>2013/14</td>
</tr>
<tr>
<td>1.4 Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).</td>
<td>NHS England Statistics</td>
<td>Monthly average against mid-year pop. projections</td>
<td>Annually</td>
<td>6,272</td>
<td>911,285</td>
<td>688.3</td>
<td>2013/14</td>
</tr>
<tr>
<td>1.5 Patient / service user experience – Phase 1 Survey</td>
<td>Phase 1 Practices</td>
<td>Satisfaction Survey</td>
<td>Quarterly</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2014/15</td>
</tr>
<tr>
<td>1.6 Local metric: dementia diagnosis rates</td>
<td>Dementia Prevalence Calculator</td>
<td>QOF register against Exeter database</td>
<td>Annually</td>
<td>1,454</td>
<td>2,877</td>
<td>51%</td>
<td>2013/14</td>
</tr>
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</table>

## Proactive Care

<table>
<thead>
<tr>
<th>Proactive Care</th>
<th>Source</th>
<th>Methodology</th>
<th>Frequency</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline</th>
<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 No. on Case Management register</td>
<td>GP Practices</td>
<td><em>Baseline collection</em></td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Q1 2014/15</td>
</tr>
<tr>
<td>2.2 No. of patients on register informed of accountable GP or care co-ordinator</td>
<td>GP Practices</td>
<td><em>Baseline collection</em></td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Q1 2014/15</td>
</tr>
<tr>
<td>2.3 No. of patients on register with care plan</td>
<td>GP Practices</td>
<td><em>Baseline collection</em></td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Q1 2014/15</td>
</tr>
<tr>
<td>2.4 No. of patients on register who refused a care plan</td>
<td>GP Practices</td>
<td><em>Baseline collection</em></td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Q1 2014/15</td>
</tr>
<tr>
<td>2.5 No. of patients on register with a proactive planned review</td>
<td>GP Practices</td>
<td><em>Baseline collection</em></td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Q1 2014/15</td>
</tr>
<tr>
<td>2.6 No. of children being proactively case managed</td>
<td>GP Practices</td>
<td><em>Baseline collection</em></td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Q1 2014/15</td>
</tr>
<tr>
<td>2.7 No. of patients on frailty register</td>
<td>GP Practices</td>
<td><em>Baseline collection</em></td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Q2 2014/15</td>
</tr>
<tr>
<td>2.8</td>
<td>No. of patients on register with a completed pre-assessment</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>2.9</td>
<td>No. of patients on register with frailty score</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>2.10</td>
<td>No. of patients on register who have had a care and support assessment</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>2.11</td>
<td>No. of patients on register who have had a preventative assessment</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>2.12</td>
<td>No. of patients on register who have had a home consultation</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>2.13</td>
<td>No. of practice appointments available</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Annually</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>2.14</td>
<td>No. of practice appointments attended</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Annually</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
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<tr>
<td>2.15</td>
<td>No. of practice same day appointments available</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Annually</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
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<tr>
<td>2.16</td>
<td>No. of practice same day appointments attended</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Annually</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>2.17</td>
<td>Primary care frequent flyers</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
</tbody>
</table>

### 7 Day Working

<p>| 3.1 | EPIC Implementation of extended weekday GP Hours | GP Practices | Roll out of extended opening hours 6pm to 8pm Monday to Friday at 18 practices | Monthly |
| 3.2 | EPIC Implementation of extended weekend GP Hours | GP Practices | Roll out of extended opening hours 6 hours on Saturday and Sunday at 18 practices | Monthly |
| 3.3 | CRRS - Additional Capacity | SCT | Additional referrals received | Monthly |
| 3.4 | Implement recommendation of Therapy Review | BSUH | All patients have therapy plan in place on admission | Quarterly |
| 3.5 | Frailty CQUIN | BSUH | Implement range of quality standards including frailty | Quarterly |</p>
<table>
<thead>
<tr>
<th></th>
<th>Source</th>
<th>Methodology</th>
<th>Frequency</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline</th>
<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.6</td>
<td>Hospital Frailty Team - Implementation</td>
<td>BSUH</td>
<td>Implement as part of HRDT - case management on Vallance and Chichester Ward</td>
<td>Monthly</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3.7</td>
<td>Hospital Frailty Team - Implementation</td>
<td>BSUH</td>
<td>Reduced LOS for patients managed by frailty team</td>
<td>Monthly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.8</td>
<td>Hospital Frailty Team - Discharge in 72 hours</td>
<td>BSUH</td>
<td>Care overview by Care of the Elderly Consultant from arrival to discharge in less than 72 hours</td>
<td>Monthly</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3.9</td>
<td>Additional Social work capacity to streamline discharge for mental health patients</td>
<td>BSUH</td>
<td>Neville Hospital</td>
<td>Monthly</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3.10</td>
<td>Additional investment in Lighthouse Service</td>
<td>SPFT</td>
<td>Support for people with personality disorder</td>
<td>Monthly</td>
<td></td>
<td></td>
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<tr>
<td>3.11</td>
<td>Care home in reach</td>
<td>ASC</td>
<td>Expand the team to increase capacity for proactive work with care homes to help avoid unnecessary hospital admissions</td>
<td>Monthly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.12</td>
<td>Care home in reach</td>
<td>ASC</td>
<td>Reduction in admissions for patient with dementia</td>
<td>Monthly</td>
<td></td>
<td></td>
<td></td>
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</table>

**Supported Discharge**

<table>
<thead>
<tr>
<th></th>
<th>% Discharged to usual place of residence - BSUH</th>
<th>SUS</th>
<th>B&amp;H CCG @ BSUH</th>
<th>Monthly</th>
<th>50,229</th>
<th>52,794</th>
<th>95%</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2</td>
<td>% Discharged to usual place of residence - Craven Vale</td>
<td>BHCC</td>
<td>All admissions</td>
<td>Monthly</td>
<td>168</td>
<td>301</td>
<td>56%</td>
<td>2013/14</td>
</tr>
<tr>
<td>4.3</td>
<td>% Discharged to usual place of residence - Knoll House</td>
<td>BHCC</td>
<td>All admissions</td>
<td>Monthly</td>
<td>78</td>
<td>143</td>
<td>55%</td>
<td>2013/14</td>
</tr>
<tr>
<td>4.4</td>
<td>% Discharged to usual place of residence - Highgrove Nursing Home</td>
<td>Victoria Nursing Home</td>
<td>All admissions</td>
<td>Monthly</td>
<td>125</td>
<td>179</td>
<td>70%</td>
<td>Apr 2013 - Dec 2013</td>
</tr>
<tr>
<td>4.5</td>
<td>Weekend discharges - BSUH</td>
<td>SUS</td>
<td>B&amp;H CCG @ BSUH</td>
<td>Monthly</td>
<td>7,336</td>
<td>52,794</td>
<td>14%</td>
<td>2013/14</td>
</tr>
<tr>
<td>Source</td>
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<td>Frequency</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Baseline Year</td>
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</tr>
<tr>
<td><strong>4.6 Weekend discharges - Craven Vale</strong></td>
<td>BHCC</td>
<td>Monthly</td>
<td>18</td>
<td>301</td>
<td>6%</td>
<td>2013/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4.7 Weekend discharges - Knoll House</strong></td>
<td>BHCC</td>
<td>Monthly</td>
<td>17</td>
<td>143</td>
<td>12%</td>
<td>2013/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4.8 Weekend discharges - High grove</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4.9 Short Term Services 48hr referral to admission</strong></td>
<td>SCT</td>
<td>Monthly</td>
<td>427</td>
<td>937</td>
<td>46%</td>
<td>2013/14</td>
<td></td>
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<tr>
<td><strong>4.10 Older people (65+) who were offered reablement services following discharge from hospital</strong></td>
<td>ASC-CAR</td>
<td>Annually</td>
<td>0.07</td>
<td></td>
<td>0.07</td>
<td>2013/14</td>
<td></td>
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</tr>
<tr>
<td><strong>4.11 Delayed transfers of care from hospital which are attributable to adult social care, per 100,000 pop.</strong></td>
<td>DToC</td>
<td>Annually</td>
<td>120%</td>
<td></td>
<td>120%</td>
<td>2013/14</td>
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</tbody>
</table>

### Integrated Frailty Phase 1

<table>
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<tr>
<th>No.</th>
<th>Description</th>
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<th>Denominator</th>
<th>Baseline Year</th>
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<tbody>
<tr>
<td>5.1</td>
<td>No. of patients on frailty register</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
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<td>TBC</td>
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<td>5.2</td>
<td>No. of patients on register with a completed pre-assessment</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
<td>TBC</td>
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<td>TBC</td>
</tr>
<tr>
<td>5.3</td>
<td>No. of patients on register with frailty score</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
<td>TBC</td>
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<tr>
<td>5.4</td>
<td>No. of patients on register who have had a care and support assessment</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>5.5</td>
<td>No. of patients on register who have had a preventative assessment</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>5.6</td>
<td>No. of patients on register who have had a home consultation</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>5.7</td>
<td>No. of practice appointments available</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Annually</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
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<tr>
<td>5.8</td>
<td>No. of practice appointments attended</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Annually</td>
<td>TBC</td>
<td>TBC</td>
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<tr>
<td>5.9</td>
<td>No. of practice same day appointments available</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>Annually</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
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<tr>
<td>5.10</td>
<td>No. of practice same day appointments attended</td>
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<td>Baseline collection</td>
<td>Annually</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
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<tr>
<td>5.11</td>
<td>Primary care frequent flyers</td>
<td>GP Practices</td>
<td>Baseline collection</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
</tbody>
</table>

### Integrated Homeless Phase 1

86
| 6.1 | No. of patients registered with a GP practice | GP Practices | Baseline collection | Quarterly | TBC | TBC | TBC | Q2 2014/15 |
| 6.2 | No. of patients registered with a dentist | GP Practices | Baseline collection | Quarterly | TBC | TBC | TBC | Q2 2014/15 |
| 6.3 | No. of homeless A&E attendances | BSUH | Baseline collection | Quarterly | TBC | TBC | TBC | Q2 2014/15 |
| 6.4 | No. of homeless NEL | BSUH | Baseline collection | Quarterly | TBC | TBC | TBC | Q2 2014/15 |
| 6.5 | No. of pathway plus | Pathway Plus | Baseline collection | Quarterly | TBC | TBC | TBC | Q2 2014/15 |
| 6.6 | No. receiving housing related support | ASC | Baseline collection | Quarterly | TBC | TBC | TBC | Q2 2014/15 |

**Personalised Care (see proactive care also)**

| 7.1 | No./Percentage of CHC adults with a Personal Health Budget |  | Monthly |
| 7.2 | No./Percentage of CHC children in receipt of a Personal Health Budget |  | Monthly |
| 7.3 | No./Percentage of patients with LTCs/Frailty/Mental health/Homeless/Children with Complex Needs in receipt of PHBs |  | Monthly |
| 7.4 | No. of all PHB holders admitted to hospital within 3/6/12 months of receiving PHB |  | Monthly |

**Supporting Carers (see Protecting Social Care also)**

<p>| 8.1 | Carers receiving needs assessment or review and a specific carer’s service, or advice and information |  | Monthly |
| 8.2 | Number of carers accessing breaks |  | Monthly |
| 8.3 | Carers satisfaction via the annual ASC Carers Survey |  | Monthly |
| 8.4 | Number of carers reporting a positive outcome from |  | Monthly |</p>
<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
<th>Frequency</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline</th>
<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>the intervention of the Carers Reablement Project, via the Carers Outcome Star data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Keeping People Well</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.1</td>
<td>NOF Domain 1: Potential Years of Life Lost (PYLL) from causes considered amenable to health care (all ages)</td>
<td>Levels of Ambition Tool</td>
<td>Rate per 100,000</td>
<td>Annually</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9.2</td>
<td>NOF Domain 2: Proportion of people feeling supported to manage their condition</td>
<td>GP Patient Survey Q.32</td>
<td>'Yes, definitely' or 'Yes, to some extent'</td>
<td>Annually</td>
<td>1338</td>
<td>2130</td>
</tr>
<tr>
<td>9.3</td>
<td>NOF Domain 2: Employment of people with long-term conditions</td>
<td>HSCIC Indicator Portal</td>
<td>Gap between LTC patients and general pop. %</td>
<td>Quarterly</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9.4</td>
<td>NOF Domain 2: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)</td>
<td>HSCIC Indicator Portal</td>
<td>Directly standardised rate per 100,000</td>
<td>Annually</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9.5</td>
<td>NOF Domain 2: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s</td>
<td>HSCIC Indicator Portal</td>
<td>Directly standardised rate per 100,000</td>
<td>Annually</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9.6</td>
<td>NOF Domain 2: Health-related quality of life for carers</td>
<td>HSCIC Indicator Portal</td>
<td>Directly standardised average EQ-5D T score</td>
<td>Annually</td>
<td>631</td>
<td>780</td>
</tr>
<tr>
<td>9.7</td>
<td>NOF Domain 2: Employment of people with mental illness</td>
<td>HSCIC Indicator Portal</td>
<td>Gap between MH patients and general pop. %</td>
<td>Quarterly</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Protecting Social Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASCOF Domain 1. Enhancing quality of life for people with care and support needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.1</td>
<td>Social care-related quality of life</td>
<td>User survey</td>
<td>The quality of life of users based on outcome domains of social care related quality of life. The maximum positive score for the outcome is 24.</td>
<td>Annually</td>
<td>19.7</td>
<td></td>
</tr>
</tbody>
</table>

88
<table>
<thead>
<tr>
<th>ASCOF Domain 2. Delaying and reducing the need for care and support</th>
<th>ASCOF Domain 3. Ensuring that people have a positive experience of care and support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10.13</strong> Older people (65+) who were offered reablement services following discharge from hospital</td>
<td><strong>10.14</strong> Delayed transfers of care from hospital which are attributable to adult social care, per 100,000 pop.</td>
</tr>
<tr>
<td>ASC-CAR</td>
<td>DTOC</td>
</tr>
<tr>
<td>1. I1, lines 2, column 9</td>
<td>Number of 18+ patients delayed 12month average</td>
</tr>
<tr>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>7%</td>
<td>1.2</td>
</tr>
<tr>
<td>2013/14</td>
<td>2013/14</td>
</tr>
</tbody>
</table>

### 10. The proportion of people who use services who have control over daily life

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
<th>Frequency</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>User survey Q.3a</td>
<td>'I have as much/adequate control over my daily life..'</td>
<td>Annually</td>
<td></td>
<td></td>
<td>82% 2013/14</td>
</tr>
</tbody>
</table>

### 10. The proportion of service users who are satisfied with their level of social contact, expressed as a percentage

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
<th>Frequency</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>User survey Q.8a</td>
<td>'I have as much social contact as I want..'</td>
<td>Annually</td>
<td></td>
<td></td>
<td>51% 2013/14</td>
</tr>
</tbody>
</table>

### 10. The proportion of service users who are satisfied with their level of social contact, expressed as a percentage

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
<th>Frequency</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAP return</td>
<td>self-directed supported against all clients</td>
<td>Quarterly</td>
<td></td>
<td>78%</td>
<td>2013/14</td>
</tr>
</tbody>
</table>

### 10. The proportion of service users who are satisfied with their level of social contact, expressed as a percentage

<table>
<thead>
<tr>
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<th>Numerator</th>
<th>Denominator</th>
<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAP return</td>
<td>Via direct payment against all clients</td>
<td>Quarterly</td>
<td></td>
<td>22%</td>
<td>2013/14</td>
</tr>
</tbody>
</table>

### 10. The proportion of service users who are satisfied with their level of social contact, expressed as a percentage

<table>
<thead>
<tr>
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<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC-CAR</td>
<td>1. L1, line 1 to 5, column 9</td>
<td>Annually</td>
<td></td>
<td>14%</td>
<td>2013/14</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
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<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC-CAR</td>
<td>-</td>
<td>Annually</td>
<td></td>
<td>80%</td>
<td>2013/14</td>
</tr>
</tbody>
</table>

### 10. The proportion of service users who are satisfied with their level of social contact, expressed as a percentage

<table>
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<tr>
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<th>Denominator</th>
<th>Baseline Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC-CAR</td>
<td>Mental Health MDS CPA patients aged 18-64 recorded as employed</td>
<td>Annually</td>
<td></td>
<td>6%</td>
<td>2013/14</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>ASC-CAR</td>
<td>-</td>
<td>Annually</td>
<td></td>
<td>54%</td>
<td>2013/14</td>
</tr>
</tbody>
</table>

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<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>ASC-CAR</td>
<td>1. S3, page 1, line 15, columns 1+2+3</td>
<td>Annually</td>
<td></td>
<td>10.58</td>
<td>2013/14</td>
</tr>
</tbody>
</table>

### 10. The proportion of service users who are satisfied with their level of social contact, expressed as a percentage

<table>
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</thead>
<tbody>
<tr>
<td>Carers survey</td>
<td>Sum of the scores for Q7-12</td>
<td>Biennial</td>
<td></td>
<td>7.8</td>
<td>2012/13</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Carers survey Q.11</td>
<td>'I have as much social contact as I want..'</td>
<td>Biennial</td>
<td></td>
<td>TBC</td>
<td>2014/15</td>
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<td>Biennial</td>
<td></td>
<td>TBC</td>
<td>2014/15</td>
</tr>
<tr>
<td>10.14</td>
<td>Overall satisfaction of people who use services with their care and support</td>
<td>User survey Q.1</td>
<td>'I am satisfied/happy with the way staff help me'</td>
<td>Annually</td>
<td>Numerator</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------</td>
<td>----------------</td>
<td>-------------------------------------------------</td>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>10.15</td>
<td>The proportion of people who use services and carers who find it easy to find information about services</td>
<td>User survey Q.12</td>
<td>'Very/fairly easy to find'</td>
<td>Annually</td>
<td>Numerator</td>
</tr>
<tr>
<td>10.16</td>
<td>Overall satisfaction of carers with social services</td>
<td>Carers survey Q.4</td>
<td>'I am extremely/very satisfied'</td>
<td>Biennial</td>
<td>Numerator</td>
</tr>
<tr>
<td>10.17</td>
<td>% of carers who report that they have been included or consulted in discussion about the person they care for</td>
<td>Carers survey Q.15</td>
<td>'I always/usually felt involved/consulted'</td>
<td>Biennial</td>
<td>Numerator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11.1</th>
<th>% of patients with NHS numbers - BSUH</th>
<th>BSUH</th>
<th>Phase 1 practices who attended OP appointment</th>
<th>Monthly</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Quality</th>
<th>Data Quality Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.2</td>
<td>% of patients with NHS numbers - SPFT</td>
<td>SPFT</td>
<td>Trust level</td>
<td>Monthly</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Data Quality</td>
<td>Data Quality Year</td>
</tr>
<tr>
<td>11.3</td>
<td>% of patients with NHS numbers - SCT</td>
<td>SCT</td>
<td>Trust level</td>
<td>Monthly</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Data Quality</td>
<td>Data Quality Year</td>
</tr>
<tr>
<td>11.4</td>
<td>% of patients with NHS numbers - BHCC</td>
<td>BHCC</td>
<td>Trust level</td>
<td>Monthly</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Data Quality</td>
<td>Data Quality Year</td>
</tr>
<tr>
<td>11.5</td>
<td>% of patients with NHS numbers - SECamb</td>
<td>SECamb</td>
<td>Trust level</td>
<td>Monthly</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Data Quality</td>
<td>Data Quality Year</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Name of Health &amp; Wellbeing Board</th>
<th>Brighton and Hove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Provider organisation</td>
<td>Brighton Sussex University Hospitals NHS Trust</td>
</tr>
<tr>
<td>Name of Provider CEO</td>
<td>Matthew Kershaw</td>
</tr>
<tr>
<td>Signature (electronic or typed)</td>
<td>Matthew Kershaw 19.9.2014</td>
</tr>
</tbody>
</table>

For HWB to populate:

<table>
<thead>
<tr>
<th>Total number of non-elective FFCEs in general &amp; acute</th>
<th>2013/14 Outturn</th>
<th>2014/15 Plan</th>
<th>2015/16 Plan</th>
<th>14/15 Change compared to 13/14 outturn</th>
<th>15/16 Change compared to planned 14/15 outturn</th>
<th>How many non-elective admissions is the BCF planned to prevent in 14-15?</th>
<th>How many non-elective admissions is the BCF planned to prevent in 15-16?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23,975</td>
<td>25,919</td>
<td>24,954</td>
<td>-4.8% (QIPP)</td>
<td>-3.70%</td>
<td>-304</td>
<td>-964</td>
</tr>
</tbody>
</table>

For Provider to populate:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>BSUH agrees that the movement from 2014/15 to 2015/16 volumes is the required level of activity reduction to deliver the projected disinvestment in acute services. Work is ongoing to validate the forecast out-turn position for 2014/15. BSUH believes that the proposed BCF schemes are appropriate commissioning interventions that will improve quality and service user experience. If implemented according to plan, they have a good prospect of delivering the planned reductions in acute activity, whilst noting the risk to this articulated in the plan’s risk log and the mitigations that have been put in place. BSUH will work with its partners in Brighton and Hove to assure itself as to the delivery of the projects prior to any inclusion of BCF impacts in 2015/16 contracts.</td>
</tr>
<tr>
<td></td>
<td>Question</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2.</td>
<td>If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?</td>
</tr>
<tr>
<td>3.</td>
<td>Can you confirm that you have considered the resultant implications on services provided by your organisation?</td>
</tr>
</tbody>
</table>