West Sussex Health and Wellbeing Board

# Better Care Fund

## West Sussex Health and Social Care Economy

| | |
|---|---|
| Local Authority | **West Sussex County Council** |
| Clinical Commissioning Groups | **Coastal West Sussex** |
| | **Crawley** |
| | **Horsham and Mid Sussex** |
| Boundary Differences | **Boundaries between the local authority and the clinical commissioning groups are co-terminus.** |
| | |
| Date agreed at Health and Well-Being Board: | **Initial submission approved at Extraordinary HWBB meeting on 27 March 2014. This revised and updated version, in line with new national guidance, has been agreed 'virtually' by the HWBB in order to comply with required timescales.** |
| | |
| Date submitted: | **12.01.2015** |
| | |
| Minimum required value of BCF pooled budget: 2014/15 | **£27,929,000** |
| 2015/16 | **£56,981,000** |
| | |
| Total agreed value of pooled budget: 2014/15 | **£27,929,000** |
| 2015/16 | **£58,609,000** |

west sussex county council

NHS Crawley Clinical Commissioning Group

NHS Horsham and Mid Sussex Clinical Commissioning Group

NHS Coastal West Sussex Clinical Commissioning Group

**Authorisation and signoff**

| | |
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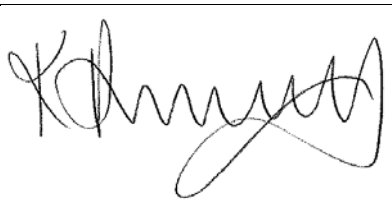
| **Signed on behalf of the Clinical Commissioning Group** |  Coastal West Sussex Clinical Commissioning Group |
| **By** | Dr Katie Armstrong |
| **Position** | Clinical Chief Officer |
| **Date** | 19 September 2014 |

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|---|---|
| **Signed on behalf of the Clinical Commissioning Group** |  Crawley Clinical Commissioning Group |
| **By** | Dr Amit Bhargava |
| **Position** | Chief Clinical Officer |
| **Date** | 19 September 2014 |

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|---|---|
| **Signed on behalf of the Clinical Commissioning Group** |  Horsham and Mid Sussex Clinical Commissioning Group |
| **By** | Sue Braysher |
| **Position** | Chief Officer |
| **Date** | 19 September 2014 |

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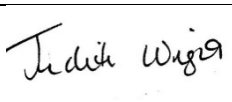
| **Signed on behalf of the Council** |  West Sussex County Council |
| **By** | Judith A Wright |
| **Position** | Director of Public Health and Commissioner for Health and Social Care |
| **Date** | <date> |

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| **Signed on behalf of the Health and Wellbeing Board** | West Sussex Health and Wellbeing Board<br><br>Delegated to JCSG – signed Judith Wright |
| **By** | Christine Field |
| **Position** | Chair of Health and Wellbeing Board |
| **Date** | 19 September 2014 |

# 1) CONTEXT

Following submission of our original plan to Health and Wellbeing Board in March 2014, the local health and care economy via the Joint Commissioning Strategic Group (JCSG) and its sub-groups have continued to develop and refine plans, based on the mandate given to them from HWBB. This document has been co-produced by the three Clinical Commissioning Groups (CCGs) and West Sussex County Council and outlines how we will jointly maximise the opportunities presented by the Better Care Fund (BCF). It outlines the overarching strategic direction and provides further detail on the agreed schemes. The document recognises that the BCF does not 'stand-alone' but is completely integrated with the planning of each of the sponsor organisations.

In moving forward the BCF will be used for genuine transformation of the health and social care system in West Sussex to meet the combined challenges of the demands of a growing older population and reducing budgets. This transformation will mean health and social care services consistently provide people with the right care, in the right place, at the right time and with care that is planned and tailored to individual capabilities and needs.

We believe that we have already embarked upon that journey, and that full realisation will take some time. However, working in partnership with all stakeholders, we feel confident that the benefits may be realised by the ultimate arbiter – the patient or service user.

# 2) VISION FOR HEALTH AND CARE SERVICES

### a) Our vision

The vision for 2019/20 is a shift from reactive to proactive health and social care to enable more people to have healthier, safer and more independent lives in their own home and community for longer, receiving the right care in the right place at the right time.

There will be a focus on ensuring more people are able to self-care and, through earlier interventions and preventative services, people will have received treatment or care earlier in their condition or problem. People's mental health as well as physical health will be supported, particularly those people with dementia and people with co-morbidities.

We will have a proactive approach to the provision of health and social care and support in the community to be delivered in partnership through GP practices, integrated health and social care multi-disciplinary teams, community based health and social care services and co-located specialist services.

Whilst we want to have first class hospitals, we need to concentrate on delivering good quality care in the community, particularly when people have a health or social care crisis that could be treated in their own home if it is safe to do so. We want to provide a health and social care system where people only have to go to hospital if they cannot be cared for in the community. To do this we will develop additional health and social care and support capacity seven days a week, particularly around hospital avoidance and discharge services.

We understand that without the support of carers the local health and social care system will face an increasing demand for services. We will therefore continue to invest in services for carers to ensure that they are able to maintain their own health and wellbeing and will also consider how we can support carers better when they or the cared for person, faces a crisis or requires a stay in hospital.

Connected information systems will ensure a smoother journey for the patient through health and social care systems, with technology and risk stratification used to ensure that patients/customers will be proactively supported and receive earlier interventions and/or more targeted treatment or care.

The BCF will act as a catalyst to support the following different ways of working:

- **Jointly managing crisis, discharge and short term interventions in the community**
- **Proactively managing Long term Conditions in partnership**
- **Developing Dementia Services in local communities**
- **Enabled by Integrated joint commissioning of services**

**b) Changes to Patient and Service User Outcomes**

Meaningful patient and public engagement is not the responsibility of one person or one team and on one occasion; it comes through a cultural shift throughout every part of the organisation from the GPs in local practices to our health and social care commissioning teams. The plans for BCF are no different to this and will form an integral part of our on-going dialogue with patients and the public.

Actions already undertaken include in 2013 a CWS review of their patient and public engagement approach which identified some key actions to establish better patient and public involvement. Several key recommendations such as a Patient Reference Panel have been implemented.

A ‘Let’s Talk’ our mechanism for continuously engaging with the public about the local NHS has been set up. This on-going programme will include workshops for patients, public and partners and public road shows. This programme will ensure local people are fully engaged in our work at every step of the commissioning cycle. Patients have already given us some key messages which have informed this strategy. These are illustrated below.

Figure 5: [1]


Horsham and Mid Sussex and Crawley CCGs have invested in work with the Commissioning Patient Reference Groups to help define their roles and how it can best and most effectively offer assurance to the Governing Bodies that the CCG is engaging wide and deep, while also having the right level of lay member insight so as to constructively challenge commissioners and help improve plans for engagement

The CCGs' public networks act as a valuable 'bank' of individual people and groups that will enable the CCGs to place patients and carer voices at the centre of BCF planning.

There is good evidence of engagement having taken place in the detailed work on individual programmes to date and Horsham and Mid Sussex and Crawley CCGs recently reached the finals in the NHS England Individual Participation Award for Commissioners and were highly commended for the proactive care programme

By 2019, through delivering a more integrated health and care system designed around the needs of local people, that offers compassionate care at the right time and puts patients/customers at the centre of all that we do, we want local people to be able to say;

- I have one number that I call when I become unwell and need advice or care
- I am supported when I become unwell or am in crisis, with the care I receive built around me
- I have access to a choice of high quality, timely and responsive services which meet my needs seven days a week
- I have one person who helps organise all of the care that I need to keep me well
- I am in control of my health, and feel listened to and involved with decisions about my care
- I feel safe and confident that I will be well looked after
- I feel part of my community and I know that I will be cared for at home for as long as possible
- My wellbeing and mental health is as important as my physical health

The outcomes metrics that West Sussex is aspiring to are set out in the part two template. The levels of ambition set have been discussed fully locally and reflect the schemes we have in place and our current local position. A summary has been provided below to demonstrate the patient and service user outcomes expected.

[1] Coastal West Sussex Clinical Commissioning Group

c) **Changes in the pattern and configuration of services over the next five years**

The pattern of delivery will shift over the next five years with a greater proportion of the CCG's and WSCC's funds being used to jointly commission care and support arrangements that are provided 7 days a week in the community. For CCGs there will be a greater relative percentage spend on primary and community based services supported by social care, with a shift from spend in acute and tertiary services.

It is anticipated that health and social care services will become more integrated and joined up. To promote independence, improve health and develop wellbeing public health, social care, primary care and community services will work more closely together to deliver co-ordinated messages and interventions to the general public and to promote a wider culture of self-care and support. There will be a coordinated approach for joint health and social intermediate care to support people to not have to be admitted to hospital, to ensure they are only in hospital for as long as is necessary and to support people through a crisis. Health and social care will also work closer together to proactively support people with long term conditions, enabling them to live independently in their own homes for as long as they are able.

These planned changes supported through the BCF will have an impact on current providers. The provider landscape for West Sussex residents is complex. In the north of the county Accident and Emergency and some District General Hospital services from outside the county boundaries and many specialist services for West Sussex residents are also outside West Sussex. This can result in long travelling distances for some patients. In addition the current configuration of service providers and the deployment of beds and services is not sustainable long term and will not support the integration of health and social care as they are currently set up. Further the implementation of the Keogh review and Sussex wide work on stroke services will also mean that there is a need to review provider configuration. The Sussex 'Unit of Planning' plan, reviewed by the West Sussex Joint Commissioning Strategic Group identifies the change to investment and spending patterns for commissioners. It is also understood that the impact for providers is not simply financial but also for workforce, clinical service delivery, models of care and estates and infrastructure.

BCF will provide the catalyst for these changes. Investment in proactive care teams will provide an opportunity for health and social care professionals to work closer together, to gain a better understanding of each other's roles and to be able to see how their work complements each other and provides improved service quality and outcomes for people. Using BCF to combine the different health and social care elements of intermediate care into a model of delivery more focussed on meeting the needs of the individual through appropriate and joined up rehabilitation and reablement episodes will benefit people as well as the system.

This will lead to the following system outcomes:

| | | |
|---|---|---|
| **A** | Permanent Admissions of older people to residential and care homes per 100,000 population | Although the number of admissions is expected to rise slightly, reflecting the anticipated growth in population and need which is outlined in our vision and case for change, the plan is to reduce the permanent admissions per 100,000 (the expressed target) in 14/15 by -2.6% and in 15/16 by -1%. |
| **B** | Reablement - The proportion of older people who were still at home 91 days after discharge | Increased spend on sub-acute reablement and better integrated and coordinated services will enable the system to move from the lowest quintile (74.4%) in 2013/14, to the England average of 81% by end 2015/16, with further improvement to over comparator Authorities of 85% by end 2016/17 |
| **C** | Delayed Transfers of Care | West Sussex in the 4th quartile (ranked 133 out of 151). The level of ambition is to move to the 3rd quartile, maintaining this in the second year. |
| **D** | Non Elective Admissions (general and acute) | The baseline position for CCGs has changed and this is reflected in our level of ambition. The reduction reflects the BCF/QIPP schemes projected for 2015/16. These calculations demonstrated that CWS could achieve 8.85% and Crawley / HMS 7.5% - giving a combined reduction of 8.4%.<br><br>The unit price was originally suggested as £1,500 in the template. Given that the bulk of the reduction will be due to proactive care which impacts on a much more complex cohort it was indicated that the case mix was more like £2,400 per admission |
| **E** | Patient/service user experience | We have adopted the Adult Social Care Outcomes Framework indicator for Social Care related Quality of Life.<br><br>Following a decline in performance in 2013-14 we plan to return to 2012-13 levels at 19.3 |
| **F** | Local Measure<br>Dementia Diagnosis Rate | The indicator is linked to our plans within Everyone Counts. The CCG breakdown is:<br>CWS – 55% to 67%<br>Crawley – 65% to 70%<br>HMS – 55% to 67% |

# 3) CASE FOR CHANGE

Public sector finances continue to face significant pressure. The rising demand for health and social care services and increased costs associated with the increasing complexity of the needs of people, is set against a backdrop of financial pressure. Budgets are not increasing to meet demand and if services continue to be delivered in the same way, West Sussex will have a significant funding gap over the next five years[2]. Whilst the wider economy begins to show signs of recovery, public services must continue to be more efficient and work with fewer 'real terms' resources. Even with small increases in NHS funding, the demand for services will outstrip those by up to £30bn by 2020 across England (NHS England (d), 2013).

Working within a reducing budget requires innovation and creativity in transformational service re-redesign which sees West Sussex County Council, Coastal West Sussex CCG, Horsham and Mid Sussex CCG and Crawley CCG wanting to broaden their own individual organisational and operational focus to consider what is available across the system and how it could be delivered using a more joined up and coordinated strategy for the benefit of health and social care customers and support efficiencies in the system.

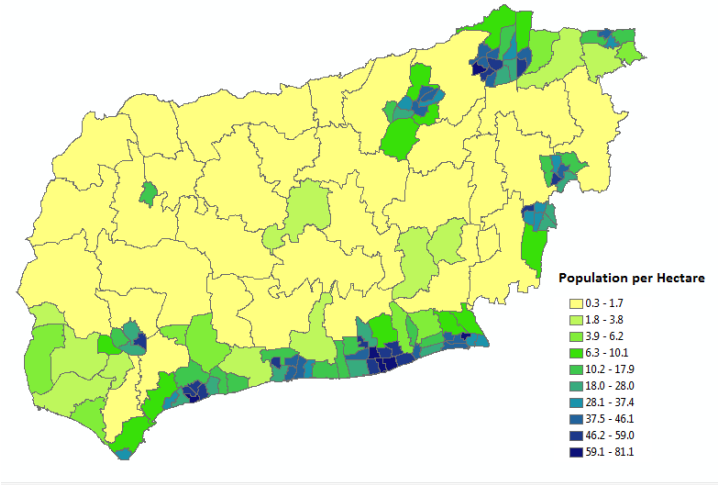
Over the next five years, therefore, community health care and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and effective joint responses to identified needs, provided in and around the home, particularly to support sub-acute and rapid access and interventions. The BCF will be used to support these transformational ideas but it is anticipated that there will be a much broader approach to include the integration of longer term proactively focussed service delivery and also for the joint / integrated commissioning of health and social care services.

<u>Increasing geographic and demographic complexity</u>

West Sussex is a large county covering some 770 square miles, and comprises a coastal strip with a series of medium size coastal towns (Shoreham, Worthing, Littlehampton, Bognor), small to medium size tows in relatively rural areas (Petworth, Midhurst, Storrington, Burgess Hill, Arundel) and large town centres (Chichester, Crawley, Horsham, Haywards Heath). Whilst this diverse and varied landscape offers a range of leisure opportunities and an excellent quality of life for many local people, there are often geographical issues in delivering consistent and equitable services.

[2] Coastal West Sussex: £201m, Horsham and Mid Sussex £73m, Crawley £43m

Figure 1: Population density in West Sussex, 2012 mid-year estimates




Population projections are not available at ward level, so the change in population density between 2012 and 2019 has therefore been estimated at district level. This is shown in the table below.

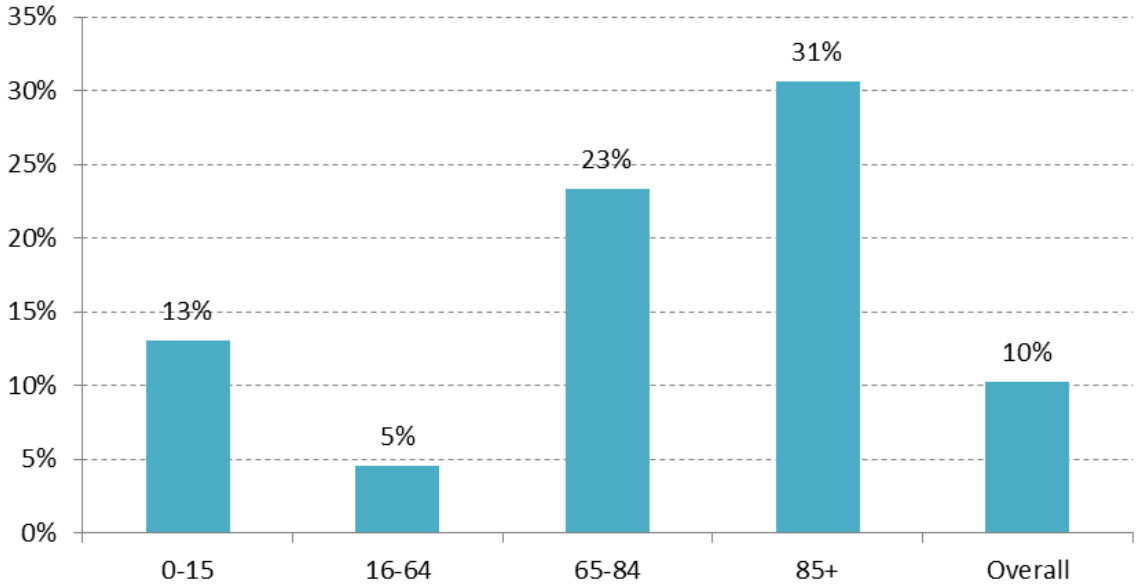
Table 1: Population density in West Sussex, 2012 and 2019 (predicted)

| | | Population Density (population per hectare) | | |
|---|---|---|---|---|
| District | Area (hectare) | 2012 | 2019 (predicted*) | % change |
| ADUR | 4180 | 14.8 | 15.5 | 4.5 |
| ARUN | 22101 | 6.8 | 7.2 | 5.7 |
| CHICHESTER | 78632 | 1.5 | 1.5 | 5.4 |
| CRAWLEY | 4497 | 24.1 | 26.0 | 7.8 |
| HORSHAM | 53026 | 2.5 | 2.6 | 4.5 |
| MID SUSSEX | 33402 | 4.2 | 4.4 | 4.9 |
| WORTHING | 3248 | 32.5 | 34.5 | 5.9 |

*Using ONS population projections

West Sussex already has one of the oldest populations in the country. Of the approximately 808,900 people resident in West Sussex, 168,100 are aged 65 years or over. This is set to grow significantly and by 2019 there will be 13% more people aged over 85 living locally in West Sussex. Other demographic changes include a reduction in the number of working age people that will create challenges in finding and developing a work force that is able to deliver high quality compassionate care. In addition, in the North of the County, there will be implications for work force, as well as increased demand for services, if the proposed second runway at Gatwick is agreed.

Figure 2: West Sussex Projected % Change 2011 to 2021[3]




Also, although West Sussex is a largely affluent area, in relation to "neighbourhood level" deprivation, West Sussex has three small areas (within River and Ham wards in Littlehampton) falling in the 10% most deprived areas in England and a further seven wards are within the most deprived 20% in England. Decline in coastal areas, such as Littlehampton, is in line with the wider national picture of coastal decline.

Life expectancy has been found to be associated with deprivation[4] and social gradients (the average change in life expectancy with each successive decile of deprivation[5]) at county level are routinely published by Public Health England (termed the Slope Index of Inequality or SII)[6]. In 2010/12, men in the least deprived tenth of the West Sussex were living 8.8 years longer than men in the most deprived tenth, up from 7.8 years in 2001-03. For women the difference has moved from 4.2 to 7.2 years. This suggests that, in West Sussex, inequalities in life expectancy has increased over the period 2001/03 to 2010/12.

The Kings Fund report on long term conditions and multi-morbidity[7] suggests most individual long-term conditions are more common in people from lower socio-economic groups, and are usually more severe even in conditions where prevalence is lower. A cross-sectional study of patients in Scotland demonstrates that multi-morbidity is more common among deprived populations, and suggests that the number of conditions can be a greater determinant of a patient's use of health service resources than the individual diseases [8].

[3] **NOTE:** The projections included in this report show projected population change to 2021. These are Sub National Population Projections (SNPP) produced by ONS in 2013.

[4] *Fair Society Healthy Lives* Marmot et al 2010

[5] Calculated from Index of Multiple Deprivation data

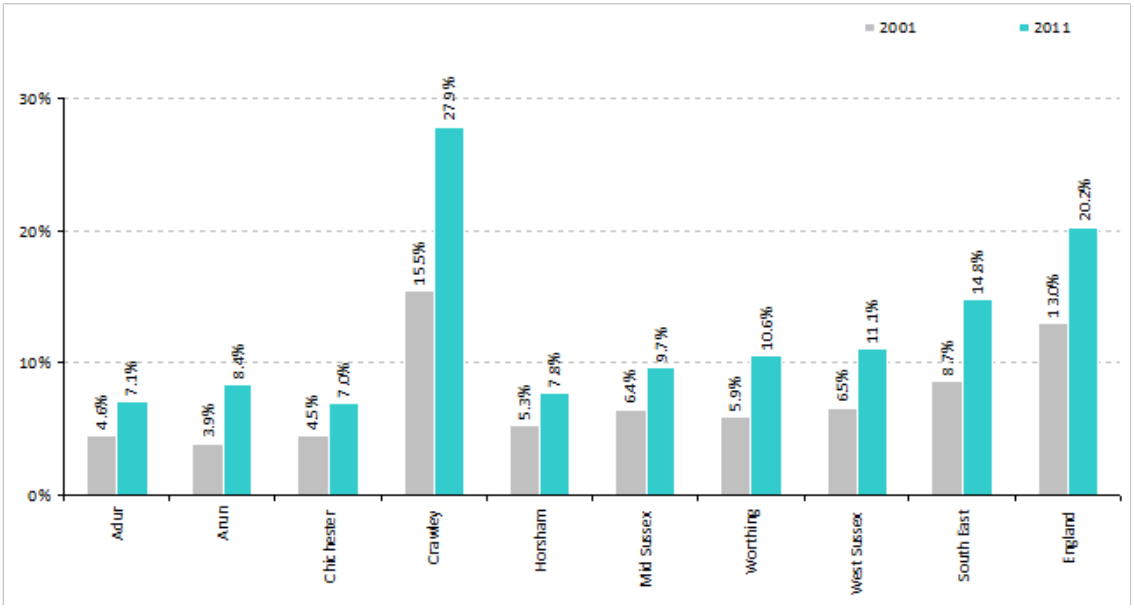
[6] APHO Health Profiles http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

[7] http://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/long-term-conditions-multi-morbidity

[8] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S and Guthrie B (2012). Research paper. Epidemiology of multi- morbidity and implications for health care, research and medical education: a cross- sectionalstudy The Lancet online

In addition, West Sussex is becoming more ethnically diverse. Data from the 2011 census show that 11% of the population is from an ethnic minority, compared with 6.5% in 2001. As with deprivation, there are differences across such a large County, for example in Crawley almost 28% of the population has an ethnic minority background, compared with 7% in Chichester.

Figure 3: Change in Ethnic Minority Background 2001 to 2011




**Despite this geographic and demographic complexity, by 2019, we will ensure that people across West Sussex will receive the right care at the right place at the right time.**

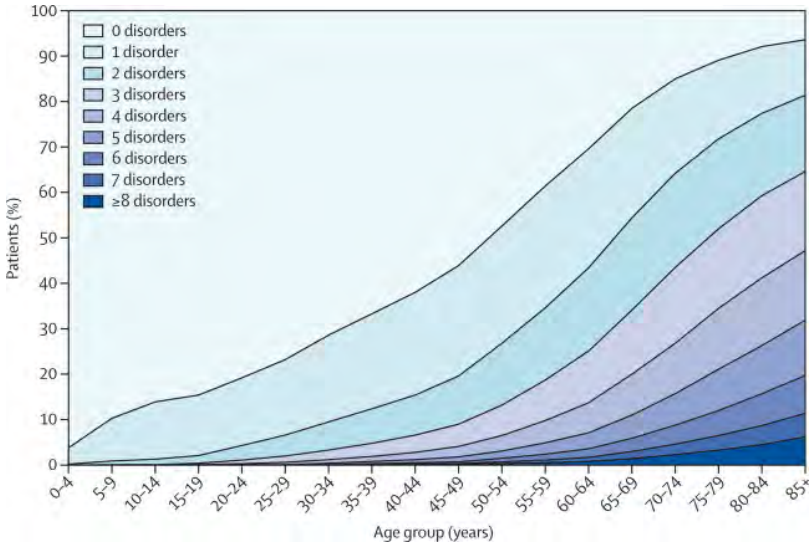
Our Proactive Care Teams (multi-disciplinary team, based around groups of GP practices) will, through risk stratification (in 2015-16 we will include social care data), identify those individuals who may require a more case managed approach to support them with their health and social care needs. In addition it is intended that there is a joint point of contact at sub-acute and rapid access services that will support people to receive health and social care services within the community, avoiding hospital or enabling effective and efficient hospital discharge, as well as ensuring people don't require further hospital care in the short term.

Without NHSfSC / BCF funding the on-going development of Proactive Care Teams would not have been able to be continued at the pace it currently is. Also discussions in relation to BCF sub-acute and rapid access developments have enabled the acceleration of work around the transformation of sub-acute and rapid access services and have identified where BCF funding would be best placed to deliver the system outcomes required. In addition BCF funding will secure Social Care services that may not have been able to have been continued.

Increasing complexity of long term conditions

The frail and elderly population account for the majority of health and social care expenditure[9], because as people live longer they often live with more long-term conditions including Chronic Obstructive Pulmonary Disease, dementia, diabetes and heart failure. From a large-scale cross-sectional study of patients in Scotland, there is evidence that the percentage of patients with one or more long-term conditions increases markedly with age (figure 4).

Figure 4: Percentage of People (by age group) with a recorded condition / disorder (Study of Scottish GP Patients)




Source: Epidemiology of multi-morbidity and implications for health care, research, and medical education: A cross-sectional study (Lancet 2012)8.

In addition there are increasing numbers of younger adults with complex conditions living longer as more extensive and sophisticated treatments have made a major contribution to curing diseases and improving outcomes. This often results in increased demand for larger packages of community based health and social care.
At a national level, it has been estimated that, between 2010 and 2030, the number of young people (18-64) with a learning disability will rise by 32.2%, and the number of young people with physical or sensory impairment will rise by 7.5%[10]

This increasing complexity of needs therefore requires a different approach to delivering health and social care services. People tell us that often they have numerous health and social care professionals to deal with and that it would be easier to have a single point of contact. People also tell us that often, if they could get the information and support they needed when they needed it, they would feel more confident in managing their long term conditions themselves.

**By 2019 we want to provide a health and social care system that enables and supports people with complexity and Long Term Conditions to look after themselves more effectively.**

[9] *'Age is a risk factor for emergency hospital admissions'* Kings Fund Report: Avoiding hospital admissions. What does the evidence say?' Dec 2010
[10] The Kings Fund: Transforming the delivery of health and social care

Through Proactive Care, people will be given advice and support around both their health and social care needs and how they can maintain their health and well-being and self-care more effectively. People will be able to contact the Proactive Care teams if they face a crisis or need additional help and support to enable them to remain independent and in their own homes. Also, BCF funding will support the development of additional dementia services, particularly around diagnosis through memory Assessment Services and crisis intervention through Dementia Crisis Teams, that will, again, provide information and support to people to enable them to be more aware of their condition and manage it better themselves. Finally BCF funding will enable the on-going development of Carers services, through expanding general information and advice services and developing Carer support services in acute settings. Through Carers people with Long term Conditions can have access to support and information about how to manage their lives.

Without NHSfSC / BCF funding the on-going development of Proactive Care Teams would not have been able to be continued at the pace it currently is. BCF funding will support the development of additional dementia and carer services which may not otherwise have been provided.

However, as a system, we also need to look at how we can prevent or delay long term conditions developing and deteriorating through early intervention and prevention services and the way we are able to proactively use risk stratification to ensure resources and services are provided to those people who are likely to have the greatest needs. In addition we will need to work with providers to ensure that their workforces are well trained and able to support people with increasing complexity of need.

**By 2019 we want to provide a health and social care system where information, advice and support, early interventions and proactive care and support, prevents or delays the deterioration of people's long term conditions.**

As mentioned above, without BCF funding, the development of our Proactive Teams and Sub-acute / rapid access may not have continued at the same pace and range. In addition, BCF funding will help the system to implement the Care Act, through being able to develop services that will ensure that WSCC are able to meet their new statutory duties around ensuring that all people in West Sussex have the opportunity to access information and support around optimising their health and wellbeing. Without BCF funding, the system would have had to find resources from elsewhere to support the implementation of the Care Act.

The BCF will also enable the CCG and WSCC commissioners to develop services to support providers of care homes to ensure that the quality of care people receive in care homes improves. This will be a mixture of proactive and reactive information, support and guidance through a multi-disciplinary team of health and social care professionals. It is also hoped that ways of providing health advice and support specifically, through linking to GPs or Consultants can be developed, along with improving the way that pharmacists support care homes with their medicine management. Through improving the quality of provision deterioration of people in care homes long term conditions may be prevented or delayed and the person will have a much better experience of health and social care.

Increasing use of acute settings

With early interventions, education, increased knowledge and awareness early on people should feel more able and be more confident to care for themselves and crisis can often be avoided. However, for a range of reasons, often intensive care and support is required when things go wrong.

Just like many parts of England, local urgent and emergency care services are facing ever increasing demand and changing patterns of disease. In 2012/13 there were over 125,000 attendances at our two local A&E departments, nearly 46,000 emergency admissions and over 80,000 calls to 999 ambulance services in Coastal West Sussex, all increasing (on average) 3% each year in recent years.

We know that some of this is related to our large and growing elderly population who often live with multiple long-term conditions including Diabetes, Chronic Obstructive Pulmonary Disease (COPD), heart failure or Dementia and require more complex care. However, some of the increase in demand can also be attributed to hospitals simply being the default setting for urgent and emergency care, firstly, due to how responsive and effective their services are, and secondly, because navigating and accessing alternative services closer to home can be complicated and confusing, and even more so for the people who don't speak English as a first language or those from hard to reach groups.

We also know most urgent care needs are not life threatening, for example, national research has shown that around 40% of patients are discharged from A&E with no treatment at all (Keogh, 2013) and locally more people are admitted to hospital for illnesses that don't usually require hospital care compared to other areas (NHS England (a), 2013). Increasing use of acute services can lead to reduced outcomes for older people and increased costs for the health and social care system. In addition there is an increasing desire for people to receive the care and support they need in their home, retaining their independence longer within their own community of friends and networks, as this has been shown to produce better outcomes for people

**By 2019 we will develop community based health and social care services that are able to respond to crisis and support people to maintain their health and well-being in their own home, rather than in acute settings, whenever possible.**

BCF funding will enable the development of 'sub-acute' and rapid access services that may not otherwise have been provided which would have resulted in people using acute settings rather than remaining in their own homes. New ways of working around jointly commissioning beds across the system to provide better 'patient flow' and linking reablement and rehabilitation services to a single jointly agreed model of intermediate care may not have progressed as quickly without the impetus of BCF joint working and funding. Community based Dementia Crisis teams will be able to be expanded through BCF funding to enable more people with Dementia to receive care and support when in crisis and support them, and their carers, to ensure that hospital or care home admission is avoided.

Increasing patient expectations

Rightly people expect the very best every time they need NHS and social care services. They expect the most up-to-date treatments and support, access to the right information and to be involved in decisions about their care and support. To deliver this the health and social care system must change the way it responds to and works with people, enabling people to take more control of the health and social care services they receive.

**By 2019 we will ensure that people are able to take greater control of the health and social care services they receive through increased use of Personal Health Budgets and Direct Payments.**

BCF has ensured that there has been improved discussions about the health and social care system and how we support individuals moving through the system. As part of these increasing discussions West Sussex has recently developed and published its Personalisation strategy, outlining how it is expected that there will be greater choice and control for people. One of the key actions is around developing plans to increase the number of Direct Payments and Personal Health Budgets and how these can be more easily joined up. Through the multidisciplinary teams being developed in Proactive Care and Intermediate Care the opportunities to expand the number of Direct Payments and Personal Health Budgets are improved.

In addition there is a growing expectation that health and social care services will be provided 7 days a week and again both health and social care providers will need to adapt to ensure they are able to meet this expectation.

**By 2019 we provide health and social care and support to people 7 days a week, particularly in respect of avoiding admission to hospital and reducing delayed transfers of care.**

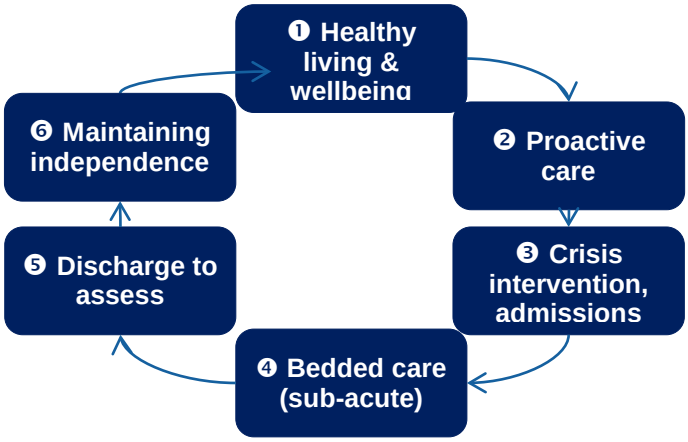
BCF funding will support the health and social care system to meet the growing expectation that health and social care services will be provided 7 days a week. We will therefore use BCF to extend services across health and social care to support 7 day admissions avoidance and hospital discharge.

# 4) PLAN OF ACTION

## a) Key Milestones

The framework for the transformation of Health and Social Care Services in West Sussex is provided by the 'Six box model' of Transformation (Care between Hospital and Home – see diagram below) which is being used as the key strategic framework and alignment for the investment of BCF pooled budgets. This plan has been shared with stakeholders and has been the foundation for the transformation plans over seen by Commissioning Boards.

Figure 6: Six box model for Transformation




We want to ensure that the outcomes from transformation through BCF schemes do not stand alone and are part of this overall WSCC and CCG framework for transforming services in West Sussex. In particular, for 2015/16, we want to use BCF to enable us to move forward in the following areas to meet our vision:

**Jointly managing crisis, discharge and short term interventions in the community**

In order to ensure that people are supported effectively when they are in crisis, it is anticipated that health and social care professional contact, crisis assessment and short term care planning and coordination services could be integrated into a single sub-acute short term team made up of health, therapist and social care professionals. This team would receive the referral and then, following assessment and planning, broker appropriate services from a range of commissioned services, for example, but not limited to equipment, Telecare / Telehealth, bedded care (step up / down beds), rehabilitation services or urgent care and support at home services, that have been made available to them. It is likely that these services would be provided on the basis of 'rapid access' – that is delivered within a time frame of no more than 4 hours.

The intention would be that for a short term period of no more than 6 weeks, the team would coordinate the care of people referred to it, with the intention of having the positive outcome of the person returning / remaining at home independently with no further or additional care and support services required than they had when their crisis started. BCF would support the integration of the operational teams in addition to increasing

capacity in commissioned services to meet the increased demand for out of hospital short term services.

In addition, for those people who do require more long term support when being discharged from hospital there would be improved support for people and their carers whilst in hospital. We are planning to introduce a service that will support carers to help find appropriate care homes for their cared for person and also a service to support self-funders, that is those people who may not ordinarily receive social care services, to choose care homes if required as we are aware that a number of very long term delayed discharges of care relate to people not being able to choose a care home. BCF would support increased capacity in these services

**Proactively managing Long term Conditions in partnership**

Proactive Care

There is increasing evidence from current proactive care work in West Sussex and elsewhere that taking a proactive multi-disciplinary team approach to supporting people identified through risk stratification as those who may be high level users of health and social care services can provide better outcomes for individuals and savings for the health and social care system through admissions avoidance.

Our proactive care programmes bring together professionals from different disciplines from community and primary care services, social care and mental health services, housing and voluntary sectors. Risk stratification tools, that it is intended will include social care, community care and mental health data by 2015, are used to identify patients who are at risk of acute hospital admission or who would benefit from an integrated approach to delivering their care. Each patient under the proactive care team has a named accountable professional who develops personalised integrated individual plans, accessible to clinicians involved in the patients care to enable better clinical decision making, and coordinates the patients care.

There is evidence that the integrated plan prepared by the proactive care team reduces ambulance conveyance (patients with a proactive plan have 28% conveyance rate compared to 67% conveyance rate for patients not on Proactive Care) and admission to hospital (demonstrated through acute pseudonymised information on a reduction in acute activity for patients on the proactive care caseload). There is additional information available through the ambulance trust;

As a system we will therefore continue to invest in and develop the proactive care programmes in Costal West Sussex, Crawley and Horsham and Mid-Sussex CCGs to;

- Reduce emergency admissions and Accident and Emergency attendances
- Reduce the number of people in long term funded residential and nursing home placements
- Enable the local population to self-manage their long term conditions, to remain independent and promote wellbeing.
- Be used as the first step towards the integration of wider adult services / community health care assessment and care planning teams.

Carer Services

Whilst proactively supporting people we also need to ensure that their Carers receive the right support. According to the Census 2011, over 84,000 people in West Sussex stated that they provided unpaid care. Of those providing unpaid care the percentage of carers caring for 20 hours of more has increased from 26% in 2001 to 31% in 2011. In addition, carers of elderly people are often a partner of a similar age[11], often with their own health problems. Data collected as part of the West Sussex Older People Survey in 2013 showed that carers providing full time care, and living with the person they cared for, were more likely to be lonely.

Engaging and supporting carers is a key part of an integrated approach and developing proactive and preventative approaches. Whilst not directly providing savings for the system, if the health and wellbeing of carers is not supported, the cost of carer breakdown could be quite high, for example a permanent admission to residential care for a single cared for person could be as high as £22,000 per annum and the on-going additional physical and mental health care costs of the carer, and cared for person, could be as high as £10-12,000 per annum.

Assistive Technologies

The Local Authority and CCG's in West Sussex have signed off joint commissioning intentions for the commissioning of assistive technologies over the next 5 years. In addition to enabling people to remain in their own homes, assistive technologies have been shown to provide savings for the health and social care economy. Research by Chichester University on the current Telecare service has shown that for every £1 spent on Telecare there are savings of over £3 for the health system and around £1.50 for social care. The Government's 3millionlives campaign considered the potential cost savings CCG's could achieve based through Telehealth, with the paper 'Effect of Telehealth on use of secondary care and mortality', concluding that a 20% reduction in emergency admissions was achieved during the trial when technology was used appropriately.

Quality in Care Homes

One area where there is system wide consensus around an issue facing people with long term conditions is on the need to improve the quality of service in Care Homes. Recent local cases of where quality on Care Homes may not have been managed as well as it should have done have indicated that there is a need for both health and social care to review how they support local Care Homes. In addition the cost of admissions into hospital direct from care homes and for health and social care if a care or nursing home provider ceases to trade and closes can place strain on the system. At a local level, therefore, it is intended that BCF be used to develop a new multi-disciplinary health and social care team that will work together to support care homes. In addition we will work with care home providers to ensure that their workforces are well trained and able to support people with increasing complexity of need.

Implementation of The Care Act

As part of our approach to proactively supporting people with long term conditions, we are taking an integrated and shared response to the increase in the statutory duties West Sussex County Council will face, from April 2015, as it implements the Care Act.

[11] A 2014 WSCC analysis of cases entering residential care in 2013/14 noted that the average age of 87 (females) and 83 (males), and that where informal care was provided prior to entry 37% of these cases were provided care by a spouse or partner likely to be of a similar age.

This will require cooperation between the Local Authority, CCGs, acute and community trusts, district and borough councils, HMP service, as well as work with voluntary, private and community based providers and organisations.

The Care Act will have wide ranging implications for the local West Sussex health and social care system. For example it is anticipated that by 2017 the number of assessments that need to be carried out by Adult Services will almost double. The increases in demand across the system highlights the case for a joined up approach to assessment and intervention to not only help manage the increases in demand but also to provide an improved, customer centric approach to residents of the County in terms of their access to health and social care services. A conservative estimate indicates an average 5-10% overlap in assessments between health and social care within short term interventions, however there is a much higher percentage of overlap in term of data captured and the associated duplication that this involves.

£2.017m is the West Sussex proportion of the £135m that has been identified within the BCF nationally for implementation of new Care Act duties.

**Dementia Services**

With the increase in the numbers of older people, where the greatest proportion of prevalence of dementia is found, of all long term conditions the number of people with dementia will grow, in volume terms, the greatest. There are currently 13,000 people living in West Sussex with Dementia and this is set to grow by 14% by 2017 and by 26% by 2021. Dementia will affect all parts of a person's life and can have a profound effect on their families. Due to this dementia has an impact on all aspects of health and social care, with an increased predicted associated health and social care cost of 25% over the same period.

In West Sussex the BCF will be used to complement existing services by providing additional capacity and provide new services as set out in the West Sussex Dementia Framework that has been agreed and signed up to by the Local Authority and three CCG's. The following themes were developed based upon evidence and in partnership with health, social care, third sector, people living with dementia and their carers in order to affect a shift to prevention and delaying / reducing the need for more complex and expensive provision:

- Prevention - both promoting healthy life styles to reduce incidents of vascular dementia, and raising awareness of dementia across the general public in West Sussex
- Recognising there is a problem – improving early diagnosis rates and ensuring staff are aware of what steps to take to support people to receive a diagnosis
- Discovering the condition is dementia – through the extension and further development of a Memory Assessment Service.
- Living well with dementia – to develop dementia friendly communities, ensure that person centred, integrated approaches are taken, ensure that carers are supported in their roles, ensure there is meaningful activities, ensure that professional health and social care staff are better informed and ensure that there are sufficiency of quality environments for care and support for treatment and residential provision for those who can no longer be supported at home.
- Getting the right help at the right time – ensure that people with dementia, their families and carers have access to the right information at the right time

- Nearing the end of life – to support the roll-out of advance care plans and ensure that staff are trained to understand the importance of such care planning and how to support people with dementia and their carers throughout the end of life stage.

**Seven Day Working**

Rightly people expect the very best every time they need NHS and social care services. They expect the most up-to-date treatments and support, access to the right information and to be involved in decisions about their care and support. To deliver this the health and social care system must change the way it responds to and works with people, enabling people to take more control of the health and social care services they receive.
In addition there is a growing expectation that health and social care services will be provided 7 days a week and again both health and social care providers will need to adapt to ensure they are able to meet this expectation.

Also, it is clear that currently some health and social care services that support avoiding admission to hospital or support discharge from hospital only operate 5 days a week, meaning that some length of stays are extended over periods when no services are available.

The NHS Services, Seven Days a Week Forum sets out the case for seven day working , in a whole system approach that spans health and social care leading to an improvement in patient experience and outcomes[12]

We will therefore use BCF to extend services across health and social care to support 7 day admissions avoidance and hospital discharge.

Key milestones are outlined in Annex 4 and the programme detailed sheets. A delivery group (subgroup of JCSG) has been established to bring together local projects and programme plans into a BCF programme plan. This will not replace local priorities and focus but ensure that plans are cohesive and designed to maximise impact on the whole system.

**b) Governance**

Governance Mechanisms
The County Council and the three CCGs have inherited a strong set of governance mechanisms for their existing joint commissioning budgets which forms a strong basis for future governance. The principle of openness and transparency is a core value that has been adopted throughout the process of developing the BCF specific schemes.

BCF will be governed through existing joint health and social care boards wherever possible, with as few extra governance arrangements set up. As well as reducing bureaucracy and additional meetings, this arrangement will ensure that BCF schemes are developed alongside / within other strategies, frameworks or operational delivery plans being developed jointly or within the CCG's or West Sussex County Council.

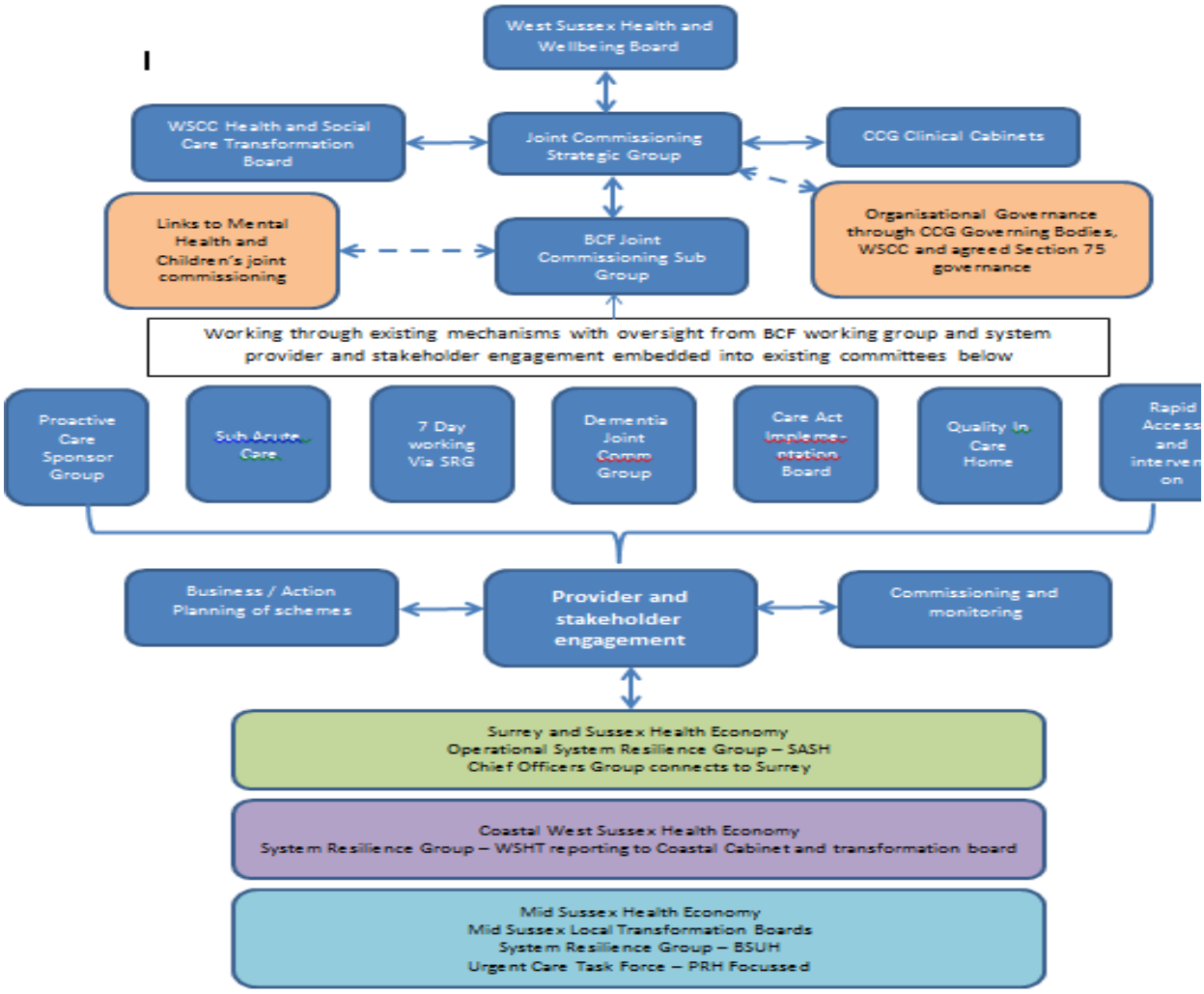
[12] NHS Services, Seven Days a Week Forum – Evidence base and clinical standards for the care and onward transfer of acute inpatients

These arrangements do not negate the need for individual commissioners (CCG and County Council) to retain organisational responsibility and sign off of plans will take place through usual governance processes.

Governance with provider organisations is provided through existing partnership working arrangements, with provider organisations part of CCG Clinical Cabinets. In addition providers are either already part of the working groups listed below in Figure 6 or will be invited to attend or engage in groups where they are not already members.

In 2014/15 NHS Funding for social care has been deployed in line with existing governance processes, outlined in a Section 75 arrangement, and is subject to discussion and agreement through the JCSG. While these arrangements are expected to continue from 2015/16, there remains a need to review the detailed terms of reference to ensure that they will be compatible with the different requirements that the BCF will bring. In addition to the mechanisms for agreeing individual business cases, consideration is yet to be given to whether there will be advantages from the County Council holding the pooled budget, because of the greater flexibilities that are available to it.

Figure 7 – BCF Governance and management framework



Governance Framework

The West Sussex Health and Wellbeing Board role, on behalf of West Sussex County Council and Coastal West Sussex, Crawley and Horsham and Mid Sussex CCG's, is one of sign off for the BCF plans and on-going oversight of the implementation of the schemes and delivery of the vision and outcomes. The operational governance for BCF will be provided by the Joint Strategic Commissioning Group (JCSG) with all four partners signing off funding allocation and detailed business cases. Figure 7 above shows the main governance and management structures and inter-relationships.

The diagram above shows the main BCF mechanisms. These are linked into existing system governance structures, covering CCG and Local Authority Commissioners, Acute and Community health providers and Adult Social Care, in a number of ways. Specifically, the provider engagement and links into all the main BCF schemes is through the existing system resilience groups and transformational boards which are in place around each Health economy. Relating to the West Sussex BCF these are specifically:

Operational System Resilience Group – SASH
Chief Officers Group connects to Surrey
System Resilience Group – WSHT reporting to Coastal Cabinet and transformation board
Mid Sussex Local Transformation Board
System Resilience Group – BSUH
Urgent Care Task Force – PRH Focussed

The BCF working group recognises that in line with the ' Forward View into Action planning guidance for 2015/16', from April System Resilience Groups will be developing into Urgent Care and Emergency networks and the links with the sub-acute, 7 day working and rapid response BCF schemes will be established with these emerging groups. For the other schemes, Proactive Care, Quality in Care Homes, Care Act Implementation and Dementia, existing multi-agency working groups and Boards will be used to ensure that the system outcomes outlined in this plan are achieved.

Governance is determined by the individual CCG and WSCC constitutions and processes. Within NHS Horsham and Mid Sussex CCG and NHS Crawley CCG, the responsibility for determining the strategic direction lies with the Governing Bodies and these are shown in the diagram above linking into the Joint Commissioning Strategic Group. The CCG Governing Body has already approved the strategic direction outlined in the BCF plan and the detailed planning is delegated to the Executive/Delivery Group at CCG level. For WSCC the Adult Social Care and Health Transformation Board, reporting directly to the WSCC Corporate Leadership Team and WSCC Cabinet will be responsible for ensuring the outcomes identified through the BCF planning, and with wider transformational system change, are achieved.

## c) Management and Oversight of the Better Care Fund

The ultimate management of the BCF will be through the West Sussex Health and Wellbeing board, however the HWBB have delegated the management of the delivery of the BCF to the West Sussex Joint Commissioning Strategy Group (JCSG). This comprises key executives from the County Council and the three CCGs.

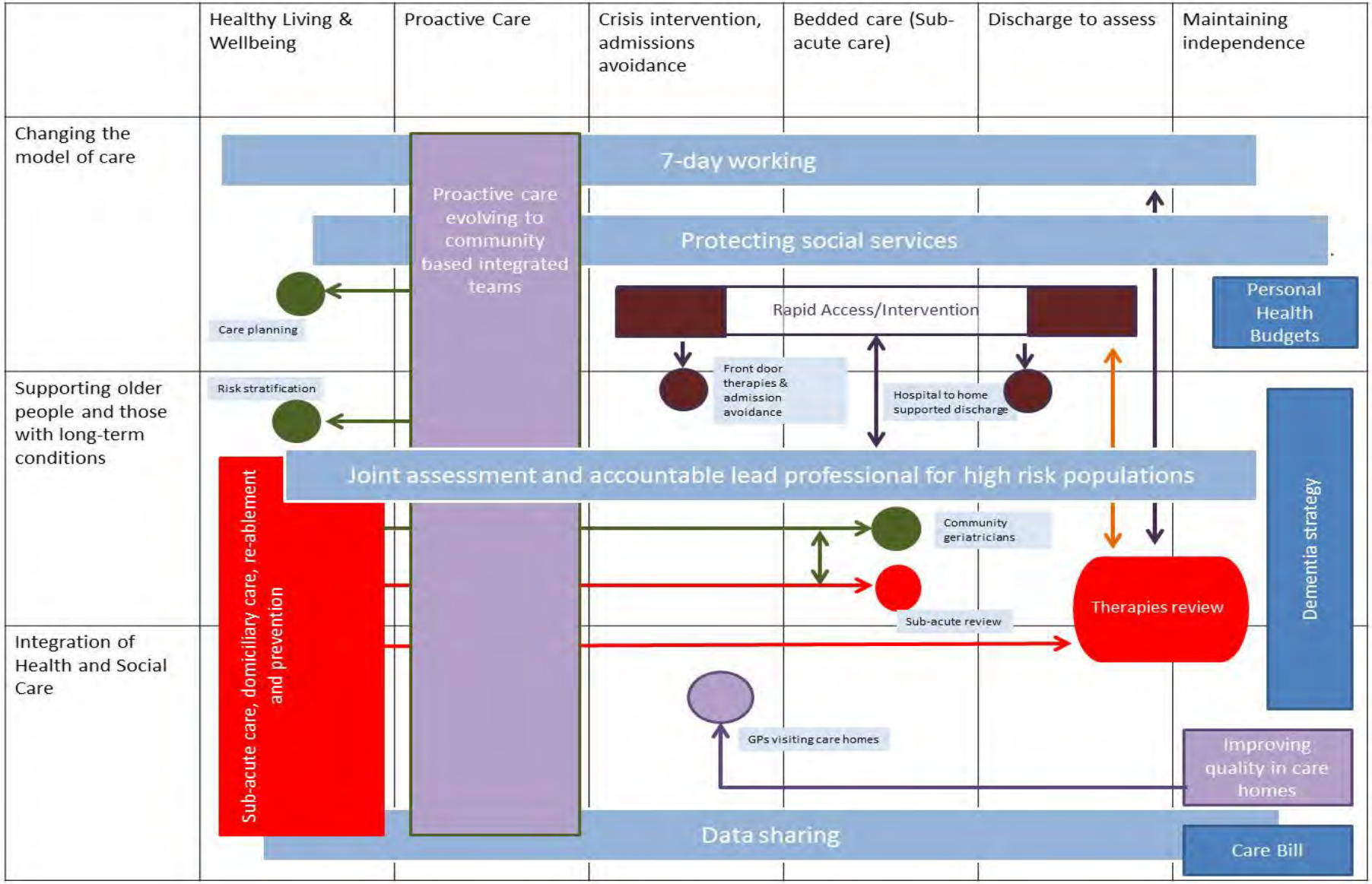
The JCSG provides the forum for the four parties to agree their approach to transforming the health and social care system through joint commissioning, integrated approaches to care and the BCF. The JCSG will also monitor progress and expenditure of the BCF and will discuss, agree and manage remedial actions should plans go off track. The JCSG is not separately accountable in itself, with each member organisation having governance and accountability arrangements at individual organisational levels. For WSCC this is the Health and Social Care Transformation Board (reporting to WSCC Cabinet as required) and for the CCGs this will be their Clinical Cabinets supported through their Local Transformation Boards.

A key agreed principle is that the BCF provides an opportunity and leverage for change but should not be dealt with outside of the whole system context.

The JCSG will be supported by a BCF Joint Commissioning Group comprising of key commissioners from the CCGs and WSCC. Through strong project management support there will be a number of working groups reporting to the BCF Joint Commissioning Group who will manage the day to day development of schemes, provider engagement and appropriate commissioning and monitoring of services. Proactive Care Boards, System Resilience Groups (for sub-acute and rapid access), Dementia Joint Commissioning Group and Care Act Implementation Board are already established and consist of health and social care representatives. New working groups around 7 day working and Quality in care Homes will be established with similar representation.

The programme diagram below (Figure 8) outlines the key relationships and interdependencies which have been identified for the BCF programmes and the agreed six box model for sub-acute care. This ensures that individual work streams understand the context and inter-relationships between projects and understand the contribution that they need to make to the whole system.

Figure 8 – Inter-relationships between BCF programmes and CCG/WSCC



d) **List of planned BCF themes**

The budget for the scheme areas is agreed based on initial analysis of resource requirements and expected benefits. As described in the governance model in Section 4b, working groups will be established to further refine plans and business cases to ensure targeted and effective use of the BCF resources in line with the aims and benefit requirements of the BCF schemes set out below and in Annex 1.

All schemes and plans exist in the context of joint commissioners own strategies and plans; the BCF offers a further vehicle for accelerating and enhancing the transformation and integration that all commissioners are committed to.

The summarised schemes listed below represent the high level themes and groupings, within which will comprise a number of detailed projects. Annex 1 outlines further detail of the themes evidence base, governance and key milestones.

| Ref | Scheme |
|---|---|
| 1 | **Proactive Care**<br>Integrated multidisciplinary teams providing holistic care to identified patients, utilising risk stratification. It is recognised that existing work on proactive care will provide the stepping stone to wider system transformation and the on-going evolution and development of community based integrated proactive care teams. |
| 2 | **Sub-acute care**<br>The development of rapid access (see section 3 above), rehabilitation and reablement home or bed based services in the community that will prevent avoidable admissions to hospital or other care setting, ensure people are discharged from hospital in a timely and appropriate manner and support people through a health or social care crisis. Reference to also be given to the Sub- Acute Review recommendations and review of Therapies Services. Services to provide sub-acute care will include (list is not exhaustive):<br><br>• Community Beds to support patient flow<br>• Development Primary Care<br>• Assistive Technologies<br>• Continuing Healthcare<br>• Electronic Call Monitoring<br>• Reablement services<br>• Community Equipment Service<br>• Carer Support Services including<br>  • Carer Support – countywide<br>  • Carer Support – Short Breaks<br>  • Carer Support – In hospitals<br>  • Carer Support – Carer Health team |
| 3 | **7 day working**<br>Schemes will be developed to ensure the effective delivery of seven day services in a transformed health and social care system through the development of a Human Resources Strategy and working with and re-commissioning health and social care provision. |

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|---|---|
| 4 | **Dementia**<br>In line with the West Sussex health and social care dementia framework, develop services to ensure early diagnosis of dementia and to ensure equity of access across the county to dementia care services providing post diagnosis support and support when people with dementia are in crisis. This will be incorporated into the shared CCG and local authority dementia programme.<br>These will include (list is not exhaustive):<br><br>• Dementia Crisis Service expansion<br>• Dementia advisors / Memory Assessment Service<br>• Dementia Shared Lives<br>• Dementia Friendly Towns |
| 5 | **Rapid access and intervention**<br>The development of health and social care services that is able to respond in a prompt manner to prevent escalation of care and to keep people in their own homes. These will support reductions in hospital and other care settings admissions and avoid delays in discharge from more intensive services. These will include (list is not exhaustive):<br><br>• A&E Redevelopment<br>• One Call one Team<br>• Paramedic Practitioners<br>• Rapid Access Heart Clinics<br>• Stroke Services<br>• RAMU<br>• Admission Avoidance<br>• Children's Urgent Care |
| 6 | **Improving quality in care homes**<br>Improving quality of care in nursing homes includes developing a quality assurance (QA) and care governance framework that outlines a more proactive, supportive and proportionate relationship with the health and social care home market. In addition medical cover for care home patients will be strengthened and specialist equipment service enhanced. Initiatives to improve quality in care homes will include (list is not exhaustive):<br><br>• Care Home Matrons<br>• Care Home Pharmacists<br>• Care Home Multidisciplinary Support Team<br>• Firefly |
| 7 | **Care Act**<br>The County Council and CCG's are working together to meet the range of new duties for the County Council introduced through The Care Act. Beginning in April 2015, and over the following two years, system changes, revised processes and new services will be required to meet the requirements around the cap on care costs for people with eligible social care needs, the new rights for carers and self-funders, the new market responsibilities and for better information, advice, |

| | |
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| | advocacy and safeguarding. |
| 8 | **Project Support**<br>Systems transformation of this magnitude requires additional project and programme support over and above the 'business as usual' management resource. Identified non recurrent funding for enabling projects to support transformation of the system and movements towards better functional integration. |

# 5) RISKS AND CONTINGENCY

## a) Risk log

The most important risks to our plans have been outlined below and a full risk register will be created as one programme plan. This analysis is supported by detailed risk registers that are kept at organisational level and at programme / project level and appropriate mechanisms exist to allow the escalation of risks if required during the implementation phases.

| There is a risk that…: | Likelihood | Impact | Potential impact | Risk score | Mitigating Actions |
|---|---|---|---|---|---|
| **BCF plans not achieved** | 4 | 4 | Financial impact on the performance fund of £6.775m based on 3.5% emergency activity.<br><br>Impact falls on schemes which would have been funded by the BCF – could be health or care providers. | 16 | Monitoring of BCF plans through JCSG (on-going)<br><br>Working with HEE KSS (on-going)<br><br>Workforce planning (on-going) |
| **Use of the BCF fails to deliver national conditions and funded schemes lead to an increase in the number of admissions to residential and care homes or other Local Authority commissioned services.** | 4 | 4 | Reputational damage<br>Financial impact on Local Authority budgets – Scale will depend on many factors, but for every 100 additional admissions to residential and care homes the potential risk to the County Council will be around £2.5m | 16 | Management of residential and care home contracts (on-going)<br><br>KPIs in scheme contracts mitigate against admissions to nursing homes (Mar 2015)<br><br>Managed reduction in social care spending (as required)<br><br>*However, as 85% of the budget is linked to eligibility, the likelihood is that this would impact on spending in areas such as prevention that could have adverse longer-term system implications* |
| **The CCG 14/15 out turn position and activity growth caused by factors including frailty and demographics means a greater level of NHS savings (8.4% reduction in NEL) required than** | 4 | 4 | Greater pressure on services and budgets<br><br>Financial impact on CCG budgets and provider sustainability<br><br>Dependent on volume risk | 16 | Planning for higher levels of reduction in NEL (complete)<br><br>Risk sharing and contingency plans agreed (Dec 2014) |

| | | | | | |
|---|---|---|---|---|---|
| **targeted (3.5% reduction in NEL)** | | | could be up to £20m | | Potential use of capitation based outcome contracts (Mar 2015)<br><br>CCG monitoring of QIPP delivery (on-going) |
| **Contract / service reductions in Acute services are not realised** | 3 | 4 | Financial impact on CCG and Local Authority budgets From the benefits table reduction in non-elective admissions £18.4m which is a activity reduction of 9.4% (section 8 part c table 3) | 12 | Monitoring of BCF plans through JCSG (on-going)<br><br>Risk sharing and contingency plans agreed (Dec 2014) |
| **Use of the BCF fails to protect Adult Social Care services** | 3 | 4 | Financial impact on Local Authority budgets Although the current plan allocates £16.5m for protection of social care, it does not provide anything for additional demand for services as a result of admissions avoidance. The range of risk is hard to estimate, but could easily extend into several millions of pounds. | 12 | WSCC Total Performance Management process (on-going)<br><br>HASC scrutiny (on-going)<br><br>Investment in demand reduction initiatives (as required)<br><br>Managed reduction in social care spending (as required)<br><br>*However, as 85% of the budget is linked to eligibility, the likelihood is that this would impact on spending in areas such as prevention that could have adverse longer-term implications.* |
| **Providers not able to mobilise workforce and capability** | 3 | 4 | Recruitment of health and social care workers in West Sussex is difficult and therefore not being able to employ sufficient workers of appropriate skills and training will mean that the transformation required will not be able to be completed | 12 | Commissioners and providers will work together to develop a workforce strategy |
| **NHS England commissioning of primary Care is not able to support system change in a timely manner, including investment in expanded services for population growth.** | 3 | 3 | Primary care providers would be unable to respond to changing management of patients outside of hospital and CCG's would not be able to offer appropriate incentives. | 9 | CCG development of co-commissioning strategies (March 2015)<br><br>SSDP process in place to identify primary care infrastructure needs (on-going) |

| | | | | | |
|---|---|---|---|---|---|
| **CCG's cannot sustain services where hospital trusts face significant financial challenges and the BCF puts additional pressure on this.** | 2 | 3 | Financial impact on CCG budgets<br>As before plus reputational damage | 6 | Use of CCG contingency monies (as required)<br><br>Performance fund not released (as required) |

## b) Contingency plan and risk sharing

The local health economy has agreed a contingency plan against the full amount of the performance fund not being available. It has been agreed that any uncommitted funds are to be held as a contingency fund. In order to effect the magnitude of change required however, the level of uncommitted funds will be very low since without investment change will not happen.

The full risk sharing agreement will be set out in the Section 75 agreement and will cover liabilities up to the value of the performance fund and the BCF.

The deliverability of the savings in the benefits plan set out above reflect a reduction in acute non elective activity of 8.4%. The risk share around the savings in the benefits plan will be set out in the Section 75 agreement reflecting the higher level of acute non elective activity reductions required.

### Risk Share Agreement

The Better Care Fund risk levels have been assessed to be in the region of £14m. Of this £6.775m relates to the performance Fund, the remainder directly to assumed savings to the 2014/15 baseline. The baselines will be recalculated in the light of recent activity as per the latest planning guidance.

The Section 75 Agreement which will govern the operation of the West Sussex Better Care Fund will recognise the £14m potential risk value. It will do this on the basis that the actual incidence of risk will lie across a range from £0 to £14m. Thus it will aim to strike a balance between:

- Avoiding being over-cautious and withholding funding from new investments that will help deliver reductions in non-elective admissions.
- Recognising the implications of existing commitments. In the short term, this means that some areas of activity, e.g. CCG reablement services and protection of social care, will be less appropriate than others for being subject to risk sharing.
- Prioritising the investment that is scheduled to be directed into those schemes which are seen as likely to have greatest immediate impact on admissions.

Of this £14m it has been agreed that £11m of risk will be borne by the commissioners (West Sussex CCGs and West Sussex County Council) the remaining £3m of risk will be mitigated within the contracts of the service providers so that they have a direct stake in the delivery of BCF priorities.

The £11m of risk to commissioners will in the first instance be mitigated by the delay in the implementation of development schemes until all relevant risks to delivery are quantified and understood. It has been agreed that the £11m of delayed implementation will be split across the following Better Care Fund streams:

| | |
|---|---|
| Proactive Care | £1m |
| Sub-Acute | £4m |
| Seven Day Working | £1m |
| Dementia | £1.5m |
| Rapid Access | £2.5m |
| Improving Quality in Care Homes | £1m |
| Total | £11m |

In terms of the operation of this risk share agreement in regard to the Performance Fund, each CCG would receive a full rebate of its relevant contribution to this Fund due to non-achievement of the Funds performance requirements as calculated by National Guidance.

The non-Performance Fund element of the Risk Share will used to mitigate each Commissioning Organisations based on their direct financial consequence of the Risks crystallising.

# 6) ALIGNMENT

The BCF schemes make up a significant proportion of the portfolio of transformation and integration in West Sussex health and social care services and are also aligned to individual organisations other service changes. For example in CCG plans changes to elective care and mental health services and medicines support to prescribers are aligned to changes in proactive care and dementia services. In social care the Care and Support at Home framework will ensure improvements and increase capacity in domiciliary care services which will enable the greater number of people to remain living in their own home and with a reduced likelihood of hospital admission.

### a) Alignment with Other Initiatives

The development of this plan reflects the commissioning intentions of West Sussex County Council, Crawley CCG, Coastal West Sussex CCG and Horsham and Mid Sussex CCG. These have been driven by the West Sussex Joint Strategic Needs Assessment (JSNA). These high level commissioning plans are part of an alignment process being led across West Sussex by the HWBB.

The alignment with the agreed ‘Six box model’ of sub-acute Care has been described in section 4 on governance.

The establishment of a Programme Management Office (PMO) to specifically support the BCF schemes and projects will ensure the alignment between BCF and other initiatives and forums. This will be linked to existing PMO type arrangements within organisations

## b) Alignment with CCG Plans

The BCF plans are part and parcel of the existing commissioning plans and are not viewed as a separate plan. There is a considerable level of risk for the CCGs in implementing the BCF, which has been highlighted in section 5. The required level of savings for each CCG in order to release monies into the pooled fund is in excess of the national guideline of 3.5% of non-elective savings and will need to be achieved through a number of QIPP schemes and cost efficiencies. Plans have also been checked for alignment with Sussex Unit of Planning Plans to ensure they are complementary.

## c) Alignment with Primary Care Co-commissioning

Our plans have been discussed and worked up with CCG executive clinical leads and practices, and joint planning is taking place in a number of ways each area. The development and co commissioning of primary care is a key priority in each CCG but in any case it is recognised that developing practices in line with our ambition is a critical success factor.
Detailed discussions regarding co-commissioning are taking place across Sussex both with other CCGS and member practices. Co-commissioning ties in with our priorities relating to the development of primary care services and any proposals that result will be considered in full with member practices and tested against other plans to ensure congruence.

Crawley CCG did not express interest in co-commissioning when invited to do so. However, the membership has since indicated they are interested in engaging in discussions taking place both with the Area Team and across Sussex.

# 7) NATIONAL CONDITIONS

## a) Protecting social care services

i) Local definition of protecting adult social care services (not spending)

Protecting social care means continuing to ensure adults who are at risk of harm, abuse or neglect are safe, as well as helping people to live independently as long as possible through person centred support.

Protecting local services means enabling the existing service to change to provide revised social care services to support the new models of care. There will be complete transparency across the whole of the BCF agenda to enable the protection of services (rather than spend). It further means agreement on the pathways and services to keep people safe to minimise cross impact on other services.

Adults Social Care Services will be available to those with long term conditions and/or age related co-morbidities at the start of their health and social care career, and not only as a result of crisis or hospital stay. Adults' Social Care is committed to facilitating independence and avoiding admission to hospital.

A key responsibility of social care services will be to ensure that high quality reablement services are available to optimise the independence and wellbeing of service users and carers. The Care Act, due to come into force from April 2015, introduces a new duty to ensure the wellbeing of individuals. Through a process of re-prioritisation it is proposed that additional resources will be invested in social care to deliver enhanced rehabilitation / reablement / rapid response services which will reduce hospital readmissions and admissions to residential and nursing home care.

BCF Funding will be allocated to meet the current level of eligibility criteria and to provide timely assessment, care management / review and commissioned services to clients who have substantial or critical needs. Information and signposting will continue to be provided to those who are not eligible for funded social care support. It is recognised that this may need to be sustained, if not increased, within the funding allocations for 15/16 and beyond if this level of offer is to be maintained, and in order to deliver integrated 7 day services. In particular as the Care Act requires additional assessments to be undertaken for people who did not previously access Social Services, due to new responsibilities to self-funders and a larger cohort of carers. There will also be a national threshold for eligibility that is based on revised criteria that will increase the entitlement of support for individuals.

Adult Social Care Services supported by the fund will be part of a whole system integrated approach that ensures there is capacity to offer choice and availability of care at home and where necessary, care and nursing home placements, and an integrated approach to end of life care.

ii) How local schemes and spending plans will support the commitment to protect social care

£16.5m is planned to be made available to protect social care services. Had this not been agreed, then cuts of around 10% of the County Council adult social care current services would have needed to be made, and this would have left the County Council with a level of services sufficient to do little more than meet its statutory duties.

The social care schemes and services protected in this Plan will all contribute to the transformation of the health and social care system across West Sussex in a way that will provide benefits to all individuals including potential users of adult social care services.

In addition, spend on protecting social care will enable social care services to develop in line with the overarching design principles and revised ways of working agreed and expressed in this Plan and this will result in benefits to the social care system.

For example, the commitment to support the funding of reablement and a wider range of other social care short term services will ensure that people, wherever possible, will be supported in their own homes to retain or regain their independence, thereby avoiding the need for longer term, more expensive, health and social care services.

In addition, the jointly agreed goal of integrated more proactive working with Health, particularly around targeting people with longer term social care needs as well as health needs, will create synergies. It is expected that these will provide efficiencies for social care, for example delaying the need for longer term residential placements, and provide more effective social care service provision for service users.

There is a clear consensus that only by health and social care working together can we ensure that the changes proposed in this BCF plan will be successful and will lead to the protection and transformation of social care services

iii) BCF Allocations for the protection of Social Care

The funding allocations within this plan are built on the principles of integration and joint working and are expressed in terms of the changes to be made rather than the recipient of the funding. The subtext is that more choice is being given about how to spend less money – none of the resources being transferred into the BCF are new money, while the County Council simultaneously faces an unprecedented reduction in its funding. The joint commissioners recognise the significant risks and challenges that this reality brings for all parties in order to move at pace to implement the integrated schemes described. These plans recognise these risks are shared and to mitigate them, are built on the principles that the schemes must deliver both:

- Protection of social care budgets in revised and existing services by at least £16.5m and
- Deliver at least a net £32m savings from CCG budgets to enable the identified investments

Inherent in the planning is an assumption that the deployment of NHS Social Care Funding in 2014/15, of up to £5.1m for schemes within social care which are intended as a stepping stone for transformation, will be maintained in 2015/16, subject to evidence of effective outcomes. The means through which the £16.5m protection for social care will

be delivered is through the schemes identified and deployment against the agreed revised services.

Also included within the plan is £2.017m for implementation of the Care Act. This is the local share of the £135m provided nationally for that purpose.

iv) Meeting the new duties

It has been agreed that an allocation of £2,017m of Better Care funding will be used to support the West Sussex health and social care system jointly meet the expectations and new duties for Local Authorities as set out in the Care Act.

Delivering the changes required in partnership with CCGs is of fundamental importance and will require transformational change and closer joint working. The following examples are some of the key areas where joint working between health and social care is planned:

- Applying the Wellbeing principle – The Local Authority, when carrying out any of their care and support functions, must actively seek to improve that adults' physical, mental and emotional wellbeing. This clearly requires integrated working as proposed in this plan to achieve this, for example through jointly delivered proactive services.
- Prevention – The Care Act requires the Local Authority to ensure the provision of preventative services that help to prevent or delay the development of care and support needs, or reduce care and support needs (including for carers). This BCF plan, particularly around short term sub-acute work, clearly articulates how health and social care services will be brought together to deliver this.
- Integration – Local Authorities must carry out their care and support responsibilities with the aim of promoting greater integration with NHS and other health related services. We, as a system, as shown in this plan, are working together to develop integrated care and support that is person-centred and tailored to the needs of those using services, particularly around joint working to plan the safe and timely discharge of NHS hospital patients.
- Carers – The Care Act places a duty on the local authority to undertake 'carer's assessments' on the basis of the appearance of a need for support. This will significantly increase the numbers of carers who will be entitled to assessment and support. This BCF Plan clearly identifies the importance that the health and social care system in West Sussex place on the need for good carer support.

The day to day implementation of The Care Act will be managed through a West Sussex Care Act Implementation Group. It will be overseen by the Adult Social Care and Health Board. Decisions in relation to implementation will be made both at Local Authority Officer and Cabinet Member level. The Joint Commissioning Strategic Group (JCSG) will be the mechanism to ensure plans develop jointly with those of the CCGs. The Health and Wellbeing Board are keen to ensure that they are also kept aware of the impact and transformation required across health and social care to deliver The Care Act.

v) Carer Specific Support

There is a commitment in West Sussex to support the, approximately, 84,000 unpaid carers in West Sussex to feel less isolated, to stay mentally and physically fit and to promote their wellbeing and life outside the carer role.

Carers funding from CCGs is shown as increasing to £1.8m from 2014/15 and in addition to the BCF minimum in 2014/15 £1.6m of funding from WSCC for carers is included in BCF funding. In total the health and social care system in West Sussex is intending to fund Carers services to a total of £3.4m

This will enable a range of services to be commissioned, supported by BCF funding that includes, but is not limited to:

- A Countywide 'open front door' service providing information, support and advice, emotional support, assessments and care planning, peer and other support groups, assistive technologies and access by Carers to direct support funding and a Carer wellbeing fund. Supporting carers to continue in their caring role through the provision of this type of service can prevent carer breakdown and improve the experience and outcomes of the cared for person. This can result in fewer admissions to hospital and could prevent the permanent admission to a care or nursing home.
- A Carer short break service providing provides respite opportunities for Carers both in their home and also away from the home, depending on the choice of the carer. It also includes a Home from Hospital support scheme for new carers. This will enable effective and efficient discharge from hospital, ensure that the person has the best chance of not having to return to hospital in the short term and will enhance the experience for both the carer and cared for person.
- Assistive Technologies for Carers that if targeted effectively can be very effective in helping carers gain and retain more independence. Using Assistive Technologies can also support the carer and improve their health and wellbeing, for example by having motion sensors to identify if their cared for person ‘wanders’ during the night the carer may have greater confidence in getting the rest they require. Assistive Technology can therefore be valuable in preventing carer breakdown and preventing avoidable admissions.
- A Carer health team, which in West Sussex has been identified as a gap in specialist clinical support to carers was identified as a concerning unmet need. Many GPs and carers were confirming that those with caring responsibilities often neglected their own health and/or missed health appointments because of their caring commitments. To support Carers a designated Carer Health team, believed to be the first of its kind, providing proactive and preventative focussed health care to carers to support the health of carers. Enabling people to continue caring can prevent the need for the cared for person being admitted to hospital and will ensure that the cared for person and carers experience of the health and social care system will be improved.
- Carer Support in Acute Hospitals will be rolled out across the County through BCF support. It provides a direct single point of access and proactive early integrated support to Carers of patients admitted into hospital. This will ensure that the Carer is supported and is able to continue their caring role upon their cared for person being discharged from hospital. This will enable the cared for person to be discharged appropriately without delay, will support the cared for person when they return home and keep them out of hospital and could prevent the need for a permanent admission to hospital.

The Carers work programme also includes support for carers of people with dementia and the wider carer duties that the Local Authority has to meet through The Care Act.

Without these services carer breakdown / crisis can occur resulting in a loss of the carers support. This is likely to lead to the cared for person requiring more intensive health and social care and support services, having more admissions to hospital, facing delayed discharge and may well require permanent residential / nursing home placement.

vi) Local Authority Budgets

When the original BCF submission was made, a plan was outlined to provide £16.5m for the protection of social care together with on-going support for County Council led investments that are being resourced from NHS Social Care Funding in 2014/15. This plan reaffirms both of those intentions, so, in principle, there are no changes in position.

What is different, however, is the impact of the decision to link the performance element of the West Sussex BCF to a reduction in hospital admissions. The risk sharing arrangements that have accompanied this development mean that the County Council's budget is now subject to an additional source of uncertainty. While that is understood as a natural implication of the way in which the BCF will operate in 2015/16, if the performance funding is not secured in full, the risk and contingency section outlines how this will impact on the BCF schemes and Local Authority budgets.

**b) 7 day services to support discharge**

The Health and Social care system in West Sussex has a strategic commitment to providing seven day working to maintain the patient flow through acute and community hospital beds. This is already part of the sub-acute review – Care between hospital and home joint work, which establishes a common language for health and social care around a six box model (see page 15) and recognises the importance of seven day working.

To ensure the effective delivery of 7 day social care services there will be a scoping exercise undertaken to identify gaps in provision, review current working, evaluate and develop recommendations and costings to ensure social workers and therapists are operational seven days a week. This work will be undertaken in partnership and close joint working with local Acute Hospital Trusts. The scoping exercise shall also consider the development of a Human Resource strategy

Current outline proposals for seven day working across health settings includes;

- Clinical Assessment Unit: Extend to 7 day working, with longer opening hours. This will be reviewed as part of our "front door, Crawley" work;
- The Acute Hospital Trusts are also discussing Therapists working 7 days a week, to support the discharge process;
- Specialist Nursing Services: These are all 5 days a week. For some (COPD for instance) there could be a case for 7 day working;
- IV Nurses: Working 7 days as this would facilitate discharge;
- Admission Avoidance Teams: Currently are 7 days a week but only until 6 pm so a case to be made for 8-8 working; and

- Integrated Discharge Team – Currently weekdays only. Additional social workers for discharge and MH liaison needed OOH.

Commissioners expect all proposals to have an impact on both emergency admissions, length of stay and discharge processes, and specifically delayed transfers of care by ensuring access to diagnostics, senior decision making, therapy services aligned to 7 day social care services and community health services, as defined in the clinical standards for 7 day working (NHS England, 2013). This network of 7 day services will mean patients are not unnecessarily admitted to hospital to await senior review or diagnostic results, and if required they will be able to be discharged on any day of the week thereby reducing length of stay and delayed discharges. This will also enhance the patient / service user experience.

Commissioners have agreed to develop system-wide plans for delivering 7 day services using £1m of BCF funding. This specific use of this funding will be deployed against those initiatives which explicitly meet one or more of the national standards for 7 day working.

Social care and health commissioners are also ensuring that 'wraparound' services, for example equipment, domiciliary care, Telecare, pharmacy services, patient transport and therapies are available seven day a week through market development and re-commissioning work with health and care providers.

**c) Data sharing**

i) Use of the NHS Number

Data sharing is a fundamental enabler to the integrated working envisioned in this plan. Integrating NHS and Social care systems around the NHS number will ensure that frontline professionals and ultimately all patients, customers and services users have access to all of the records and information that they need.

We have therefore undertaken an ambitious IT integration project to build a real time read only record viewer with data sources from both health, and for the first time, social care. Access will inform proactive care teams, professional and patient contact points and social care professionals. Access will also help A&E and out-of-hours clinicians understand any significant medical history, and what support provision was already in place in the community. For patients it will help to avoid repetition of tests or additional prescribing that they do not benefit from. In some cases timely access to this information could help avoid a hospital admission.

WSCC are committed to using NHS Numbers and are currently working with NHSIC to obtain NHS numbers for the records of current Adult Services clients. It is planned that this work should be completed by the end of October 2015.

ii) Open APIs (application Programme Interface) and Information Governance controls

West Sussex County Council as well as the CCGs are committed to using open APIs and standards. Our data integration project that combines health and Social Care data uses Open API and Open Standard technology to extract and collate multiple, disparate datasets from across West Sussex and presents the results in a read only access to

authorised clinicians or health and social care professionals at the point of care delivery. The proactive care project also already demonstrates the use of Web Service APIs and Open Database Connectivity for the sharing of data via a Clinical Patient Portal. West Sussex County Council already use GCSx secure email services to exchange information with other government secure services such as NHS.net.

The CCG's are already using NHS net emails; they are using Contract/Commissioning as well as Urgent Care dashboards with necessary access controls in place. There are well developed Information Governance arrangements and data sharing agreements in place supported by and over seen by the Commissioning Support Unit (CSU). All staff also have a mandatory duty to pass their IG training annually.

There are full information governance systems and processes in place for the existing risk stratification software and the Read only Clinical Information (ROCI) systems. Appropriate data sharing agreements and protocols are in place and are reviewed regularly. The commissioners consider all information governance risks have been mitigated and are being managed. In addition other appropriate IG controls are in place. These cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2, as evidenced by the achievement of level 2 of the IG toolkit

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

i) Approach to Risk Stratification

The CCGs and Adult Social care in West Sussex are already well advanced in their implementation of risk stratification. The proactive care programmes in each CCG adopt the same guiding principles which were outlined in the joint Sub-acute strategy while local differences in population profiles and geography have shaped local delivery. The introduction of the unplanned admissions DES this year has enabled CCGs to formalise and develop work with practices on risk stratifying and case managing vulnerable groups of people. Named clinicians and care co-ordinators are key features of this programme.

The approach to risk stratification is based on the Kings Fund combined predictive model. This relies on 2 years history of primary care and secondary care information to predict the risk of admission in the next 12 months. In Crawley Horsham and Mid Sussex CCG area, the segment of population that we prioritise in the proactive care model is 65 - 85% risk of admission. In Coastal West Sussex CCG area, it is focused on top 2% of the population and now moving towards the top 10% of the population who are at risk of admission. Work is currently being undertaken to input social care data into the risk stratification tool. Not only will this ensure social care clients are considered more within the proactive team work, but will also enable commissioners to get a much better understanding of the interactions of health and social care services within patient pathways. Additional scoping to include mental health and community data in risk stratification tools are also being reviewed

From the existing proactive care programme in place, in general, the proportion of population identified as at high risk is dependent on the geography and the long term conditions and co morbidities and is observed to vary between 0.1% to 0.5% of the total

registered population of the combined CCGs. In terms of numbers this equates to roughly between 340 to 1710 of a population of around 342,635.

In Coastal West Sussex, the top 10% of the population is approximately 12,000 patients, mainly older, however, includes younger people with complex needs.

ii) Joint Process for Risk Assessment and Lead Professional

The CCGs and West Sussex County Council are developing plans to support improved levels of joint assessment and professional accountability through our proactive care programmes. In addition to the excellent practice already present within our mental health services our proactive care MDTs will focus on the development of an accountable lead professional approach for patients/customers who have been risk-stratified and who are considered to be vulnerable and/or at high risk of deterioration and, possibly, hospital admission. We will use the £5 per head initiative set out in “Everyone Counts” to support general practitioners in developing services for over 75’s that seek to reduce risk, and avoidable admissions, linking to the work of proactive care in ensuring that a clinician is contributing and leading the development of a care plan, that the care plan is personalised to the patient/customer; GPs will be supported in doing this through the services developed as part of developing community based integrated teams including proactive care, seven day working and rapid access and intervention. Our contracts with providers will have specifications which support clinical leadership for person centred care planning and, where appropriate, we will use CQUINs to ensure incentives are in place to achieve this ambition across the next 2 years

Care provided to those at risk of admission is within proactive care and primary care. Referrals to the team are based on need of the individual. The care is personalised and the approach is holistic and not based on a specific long term condition. The assessment process is inclusive of all three areas.

The CCG’s have agreed local processes to enable appropriate coordination of proactive care from the person who knows the patient best, Identification of patients is enabled by risk stratification and professional judgement which leads the coordination and intervention to be shared between proactive care and the GP as required. .

There are seasonal variations and as can be expected at any given time patient cohorts will change as their risk declines, they are discharged from proactive care and followed up by health and wellbeing / universal services. As the health and social care system moves to greater integration, learns lessons and builds on the proactive care model to incorporate wider patient groups and pathways the identified population and the range of interventions available to address need will be expanded.

iii) Individuals at High Risk

West Sussex proactive care has been implemented on a phased basis across the county. The teams are in maturing phase where commissioners expect increased productivity as described in CCG Programme Plans. The number of individuals referred who have consented to proactive care intervention which includes a personalised care plan are shown in table 2 below along with the projected trend.

Table 2: Number of patients supported by proactive care that have a personalised integrated plan in place

| | 2014 | | | | 2015 | | | |
|---|---|---|---|---|---|---|---|---|
| | Q 1 | Q 2 | Q 3 | Q 4 | Q 1 | Q 2 | Q 3 | Q 4 |
| Coastal West Sussex CCG | | | | | | | | |
| Actual: | 1751 | 3040 | | | | | | |
| Trend: | | | 4451 | 5862 | 7273 | 8684 | 10095 | 11506 |
| Crawley and Horsham and Mid Sussex CCGs | | | | | | | | |
| Actual: | 1309 | 1863 | | | | | | |
| Trend: | | | 2417 | 2971 | 3525 | 4079 | 4633 | 5187 |

# 8) ENGAGEMENT

West Sussex recognises that provider engagement needs to be as much about engaging our clinicians in changing the way they work, as it is about the technical sign off of plans and activity shifts. To this end communications have been developed which focus on what the BCF means at clinician level. An example of this can be found here: http://www.horshamandmidsussexccg.nhs.uk/BCF

i) NHS Foundation Trusts and NHS Trusts

A joint letter from the County Council and three Clinical Commissioning Groups (CCG's) has been sent to the health providers in West Sussex outlining the work of the BCF and discussing their role within it. The joint commissioners have stressed that the BCF represents part of the on-going planning and dialogue which was already in place prior to the announcement of the BCF funding and which will continue as we go forward.

The CCG's continue to engage with providers through a series of related work streams, including:

- Urgent Care plans have been co-designed through the Urgent Care Working Groups and Boards.
- The joint 'Sub-Acute Review' with West Sussex County Council included provider consultation as part of the evidence review.
- A joint review of discharge planning processes in Coastal West Sussex has identified a number of the local plans to be supported by the BCF.
- The development of the proactive care programme consulted in the development of and includes providers within the sponsor group.
- Aligning contracting mechanisms to BCF plans such as Lead Provider arrangements for key elements of proactive care and rapid assessment and intervention schemes.

CCGs have held and have a further number of road shows and dedicated events where plans have been shared with providers.

As details of schemes are agreed within local working groups, which include provider partners, the plans will be shared via, and subject to oversight through the governance model detailed in Section 4b.

ii) Primary care providers

Primary Care (in their provider capacity) has been involved in the primary care development programme which has included development and sharing of plans. There has also been wide stakeholder input into the development of the Crawley, Horsham and Mid Sussex (HMS) Infrastructure and Wellbeing Plans (5 communities) which is on-going and will involve a second phase of stakeholder engagement and public consultation.

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

Over a number of years, the County Council has had a programme dedicated to the delivery of Prevention and Wellbeing Services. This has been the vehicle for commissioning services which help people to remain as independent as possible for as

long as possible with the Voluntary and Community Sector (VCS). A Prevention and Wellbeing framework was built upon with some significant engagement activities since its original design phase in December 2011 and the service areas have been co-designed with the VCS, as each stage of the commissioning plan has progressed.

The West Sussex Health and Wellbeing Board have led in the engagement with the VCS by drafting a Communication and Engagement Strategy. As a result of the commitments made in this document, a stakeholder workshop was held in June 2014. There were over 100 participants including service users, carers, members of local communities, voluntary and community sector organisations and statutory sector services.

The key findings from the event were that the strong, inclusive community's agenda is critical to the continuing delivery and improvements to health and wellbeing locally, especially in light of the rising demand and constraints on resource availability. It is central to the delivery of the prevention agenda at the primary, secondary and tertiary levels. Change will be needed in services and the role and relationships between people and communities and organisations.

A further stakeholder event was held on 8th September 2014, with an agenda to focus on the development of the Health and Wellbeing Strategy and the BCF as a key driver of transformation. Once again the workshop has considerable representation from the Community and Voluntary sector. Developing on this event, the West Sussex BCF represents part of the on-going planning and dialogue of the transformation of health and social care services with the Community and Voluntary sector. It is the intention that further communication and engagement with the third sector will occur as the individual schemes highlighted in the Plan are developed and commissioned.

Social Care Providers also are engaged in consultation with West Sussex County Council through a range of various mechanisms. These include the Domiciliary Care Strategy Group and a number of forums including the Mental Health and Learning Disability Forum, the Care Homes Managers Forum, the Physical Disability Forum and one off consultation events relating to specific work streams.

**c) Implications for acute providers**

The impact on each provider is summarised below in table 3. The high level intentions have been shared with providers regularly.

Discussions to align provider and commissioner intentions are on-going through local transformation boards and future provider engagement is outlined above.

Table 3: Impact on providers by Financial Year 15/16 vs 14/15 and 14/15 vs 13/14

| | Brighton and Sussex University Hospitals Trust | Surrey and Sussex Hospitals Trust | Sussex Community Trust | Other | Western Sussex Hospitals Foundation Trust | TOTAL |
|---|---|---|---|---|---|---|
| 2013/14 Outturn | £13,096 | £15,461 | £1,580 | £6,460 | £43,670 | 80,267 |
| 2014/15 Projection | £13,865 | £13,651 | £1,679 | £6,362 | £45,347 | 80,904 |
| 2015/16 Plan | £12,337 | £11,017 | £2,495 | £6,236 | £40,980 | 73,066 |
| 14/15 Change compared to 13/14 outturn | 5.87% | -11.70% | 6.26% | -1.51% | 3.84% | 0.79% |
| 15/16 Change compared to planned 14/15 outturn | -11.02% | -19.29% | 48.61% | -1.98% | -9.63% | -9.69% |
| How many non-elective admissions is the BCF planned to prevent in 14-15? | 569 | 503 | -82 | 16 | 729 | 1735 |
| How many non-elective admissions is the BCF planned to prevent in 15-16? | 1,528 | 2,634 | -816 | 126 | 5,045 | 8,517 |

# ANNEX 1 – Detailed Scheme Descriptions

| **Scheme ref no.** |
|---|
| 1 |
| **Scheme name** |
| **Proactive Care** |
| **What is the strategic objective of this scheme?** |
| **To develop community based integrated teams to offer holistic care to the growing frail elderly population and those with complex needs including long-term conditions; reducing their risk of unplanned hospital admission.** |
| **Overview of the scheme** |
| Proactive care will deliver a truly integrated approach to community based health and social care services across West Sussex.<br><br>The model will establish community based teams around groups of GP practices. These teams will comprise of nursing, therapy, social work and other clinical and administrative staff. The precise make up of each team will be based on their areas specific needs but all teams will have named care coordinators for all patients on the case load.<br><br>These teams will also be support by specialist nurses commissioned to provide specific expertise into the proactive care model and to those with specific conditions such as Parkinson's disease and Epilepsy. As well as by improved End of Life Care Services and clinical information sharing tools such as EPACCs<br><br>The teams will identify patients at risk of hospital admission and/or those who it appears may be requiring an increasing future level of health and social care services through risk stratification tools, as well as GP and other professional referrals.<br><br>Each patient will have a joint assessment and a detailed and person centred care plan developed and supported by an MDT approach and sign off. These plans will then be shared across all agencies through IBIS (a shared information services hosted by South East Coast Ambulance NHS Foundation Trust) as well as through other appropriate clinical systems, ensuring care plans are accessible to professionals when a patient requires their support. Patients will also be enabled to self-care wherever possible and supported to understand their own 'normal' health so they can be confident in which services to access based on their own understanding.<br><br>Local GPs will provide clinical leadership of Proactive Care and assume responsibility for |

their own patients on the case load.

Proactive Care will primarily support the frail and elderly and those living with complex needs including long-term conditions such as (but not exclusively) diabetes, COPD, heart failure and dementia

**The delivery chain**

<table>
<tr><th>Joint Commissioners</th><th>Lead Provider</th><th>Providers</th></tr>
<tr><td rowspan="4">NHS Coastal West Sussex CCG<br><br>NHS Crawley CCG<br><br>NHS Horsham & Mid Sussex CCG<br><br>West Sussex County Council</td><td rowspan="4">Sussex Community NHS Trust<br><br>Community nursing and therapy services including care coordinators and team leads</td><td>West Sussex County Council<br><br>Social Work services</td></tr>
<tr><td>Sussex Partnership NHS Foundation Trust<br><br>Dementia services</td></tr>
<tr><td>South East Coast Ambulance NHS Foundation Trust<br><br>IBIS system to host and share care plans</td></tr>
<tr><td>Primary Care GP Practices<br><br>To provide clinical leadership to MDTs</td></tr>
</table>

**The evidence base**

**Risk stratification**
There is growing evidence that predictive modelling or risk stratification tools can be effective in case finding those patients with a higher risk of unplanned of hospital admission. Evidence suggests that the wider range of data sources used and specifically when GP data is used the tools can be even more effective (Billings et al, 2013).

**Community-based multi-professional teams**
Ross et al (2011) indicate that community-based MDTs, designed around a group of practices can promote close working and communication between staff in different organisations that can lead to improved outcomes for patients at high risk of admission to hospital.

Imison et al (2012) also suggested areas with well-developed integrated care models have lower readmission rates and bed use.

**Case management and care co-ordination**
Evidence suggests that care co-ordination supports personal continuity for patients, as

well as leading to patients and their carers feeling more resilient in managing their own conditions at home (Goodwin et al, 2013).

This is further supported by Ross et al (2011) who suggest that there is clear potential for case management delivered through integrated teams to deliver better and more cost effective care.

The sharing of care plans is also a key enabler of effective case management; it ensures improved continuity of care and communication between professionals which can reduce duplication and increase integration.

**Local evidence**
Through 2014-15 commissioners have be gathering evidence about how effective proactive care can be in reducing conveyance to hospital, emergency admissions and bed day use. A correlation between the development of care plans and a reduced rate of emergency admission, bed day use and conveyance is apparent for the target cohort. This information has been used in the modelling of the impact set out in this plan.

| **Investment requirements** | **£12,557,000** |
|---|---|

**Impact of scheme**

Further information about how the BCF Plan impacts the patient outcomes is set out in section 2 b. This scheme will impact on the following overall outcomes:

- **A - Permanent admissions of older people (65 and over) to residential and nursing homes** – through supporting more people to live well in the community and reduce their risk of crisis
- **B - Proportion of older people (65 and over) who are still at home after discharge from hospital into reablement or rehabilitation** – through improved multidisciplinary support and care coordination
- **D - Reduction in emergency admissions** – through effective risk stratification of patients at risk of admission and developing a clear and shared care plan
- **E - Improved patient and service user experience** – through supporting more patients to self- care and live healthily in their community

**Feedback loop**

A set of metrics have been established by all commissioners working in partnership with the Lead
Provider against which the Lead Provider will be managed. Each commissioner has established regular performance management meetings with the Lead Provider where delivery against the planned outcomes is assessed and appropriate remedial actions agreed.

The measures to be used for performance management include but are not limited to:

- Increase in the number of care plans developed and shared across local providers

- Reduction in the rate of emergency admissions for patients on the case load against the background rate of emergency admission for the target patient group
    - Qualified by an absolute reduction in the number of emergency admissions for the target patient groups
- Reduction in emergency bed day use for patients staying longer than 15 days and who are on the case load
    - Qualified by an absolute reduction in the number of emergency bed days for the target patient group
- Reduction in the rate of permanent care home placements following hospital admission for the target patient group
    - Qualified by an absolute reduction in the number of permanent care home placements for the target patient group

All data will be drawn from either existing data returns or by data collections established in 2014-15.

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

- Effective engagement with primary care providers that enables clinical leadership of community based integrated teams
- The training and development of Proactive Care Team leaders and care co-ordinators to provide effective case management
- Full engagement, inclusion and joint working with all local stakeholders in a MDT, recognising the value of and benefits from working with social care, therapies, 3rd sector and other partners
- Alignment of Proactive Care with the £5per head policy in 2014-15 and national unplanned admissions DES
- Ability of MDTs to continue to develop and review care plans for an increasing number of people
- Identification of the appropriate contractual models and incentives to accelerate delivery of Proactive Care
- Commissioners establishing clear performance, information and clinical governance arrangements for the Lead Provider and other providers and the establishment of appropriate systems and processes to monitor progress against targets

**Lead**

**BCF Working Group (Debra Wheeler)**
Horsham and Mid Sussex & Crawley Proactive Care Sponsor Group (WSCC / CCG Commissioner and Community and Social Care Provider Group)
Coastal West Sussex Proactive Care Board (WSCC / CCG Commissioner and Community and Social Care Provider Group)

**Key milestones 2015/16**

| | |
|---|---|
| Quarter 1 | To develop business case for introduction of social care data into risk management tool |

| | |
|---|---|
| Quarter 1 | Provider agreements and contract agreements in place |
| Quarter 1 | MDT's in place |
| Quarter 1 | CWS Revised Proactive Care Specification in Lead Provider contract |
| Quarter 2 | Evaluation of pro-active in –reach at Worthing Hospital |
| Quarter 2 | Agree next steps on in-reach model with key stakeholders and providers |
| Quarter 2 | North Review current Proactive Care Teams |
| Quarter 3 | Roll out of proactive in-reach at local hospitals on admission, medical and older people's wards begins |
| Quarter 3 | Review of proactive care and Multispecialty Community Provider (MCP) model begins |
| Quarter 4 | All high risk patients have integrated care plan |
| Quarter 4 | Managing long  term conditions |
| Quarter 4 | Year of care training implemented |

| Scheme ref no. |
| --- |
| 2 |
| **Scheme name** |
| **Sub-Acute, Domiciliary Care, Reablement and Prevention** |
| **What is the strategic objective of this scheme?** |
| **To develop an integrated health and social care rehabilitation and reablement service that offer holistic care and support to local older people, improving their overall wellbeing and preventing future risk of hospital admission, facilitating discharge and enabling people to regain / retain their independence and remain in their own home.** |
| **Overview of the scheme** |
| Across West Sussex commissioners spend circa £7m on care and support at home. Starting with a review of this investment; commissioners seek to design and commission a single integrated rehabilitation and reablement service that is more streamlined, efficient and is able to offer better care to local people.<br><br>This will be supported by a range of primary prevention services, again targeted at the significant older population in West Sussex. These include investment in winter preparedness to reduce excess winter deaths; preventing social isolation to maintain independence; and falls prevention through strength and balance training, home hazard assessment and intervention and medication reviews.<br><br>These changes will be further supported by the consideration of re-commissioning of local community hospital beds. This will be undertaken in response to the development of a single community rehabilitation and reablement service and agreed discharge processes.<br><br>Primary Care services will also be supported to develop new ways of working with the potential for federated or collaborative models of delivery that improve access and ensure the sustainability of local primary care services.<br><br>Assistive technologies will also play a key role in successful delivery of this scheme and across other schemes such as Proactive Care, Seven Day Working and Dementia Services. We will continue to expand the use of assistive technologies and research and develop local approaches to utilising both Telecare and Telehealth systems.<br><br>Additionally work is being undertaken to look at integrating community and social care occupational therapists and physiotherapists to provide a single team that could become a key part of a range of sub-acute services designed to ensure that the patient gets the |

right care at the right time to avoid hospital admission, a social crisis or to support early hospital discharge.

To further support sub-acute provision, WSCC and CCG commissioners are jointly commissioning, and increasing investment in, Telecare Services. Telecare can enable people to remain within their own home, retaining their independence and supporting reablement and rehabilitation services delivered at home. Telecare will also be used, through ensuring a 24 hour response through current re-contracting of services, to support admissions avoidance and hospital discharge.

WSCC and CCGs are also currently jointly commissioning Community Equipment Services. A review of the service is currently being held. The revised services will include the need for the provision and installation of equipment into a person's home within 24 hours to facilitate early discharge or avoid hospital admission.

People receiving sub-acute and longer term care services often require the support of their families as carers. There are around 84, 000 unpaid carers in West Sussex (Census, 2011) and the number is set to grow. Caring, however has a major detrimental impact on the health and wellbeing of the carer. Therefore, in order for more carers to sustain their caring responsibilities and avoid family breakdown/acute care they need to be less isolated, supported to stay mentally and physically well and supported to have a life outside of the caring role.

**The delivery chain**

<table>
<tr><th>Joint Commissioners</th><th>Providers</th></tr>
<tr><td rowspan="2">West Sussex County Council</td><td>West Sussex County Council<br><br>Social Work and reablement services</td></tr>
<tr><td>Independent sector providers<br><br>Care home services and other prevention services</td></tr>
<tr><td>NHS Horsham & Mid Sussex CCG<br><br>Acting as lead commissioner on behalf of NHS Crawley CCG and NHS Coastal West Sussex CCG</td><td>Sussex Community NHS Trust<br><br>Community services supporting discharge, falls prevention and community hospital beds</td></tr>
</table>

**The evidence base**

There is evidence that these services can both reduce risk of hospital admission and facilitate earlier discharge when implemented effectively and equitably. Bed-based models of rehabilitation and reablement have been found to be more expensive than community based models (NHS Benchmarking Network, 2013), however, continue to have a place in overall system design. There is good evidence to suggest 'extra care housing' and spot purchasing care home beds to enable rehabilitation can be effective in preventing hospital admission and permanent placement in long-term care (SCIE, 2013).

Evidence suggests that strength and balance training, home hazard assessment and intervention and medication review can be effective in reducing risk of falls and subsequent hospital admission (NICE, 2013).

The Kings Fund, in their report "Transforming the delivery of health and social care" (2012)[13] , suggested that change to the delivery system of health and social care is needed in order to meet the needs of an ageing population, the changing burden of disease, and rising patient and public expectations.

This change will need to address preventing illness and tackling risk factors to help people remain in good health, supporting people to live in their own homes, providing high standards of primary care, making more effective use of community health services and related social care, integrating care around the needs of people and populations. Other reviews have emphasised the importance of early intervention and prevention in health and social care, suggesting services that are designed to ensure that people can retain their independence and quality of life may help prevent hospital admissions and delay residential placements[14].

These services will include domiciliary care and reablement. Domiciliary care, or home care, is supportive care provided in the home, is broad in its scope and promotes and extends independent living; evidence as to the effectiveness of domiciliary care on hospital admissions is mixed[15] with one study reporting a 25% reduction in acute care hospitalisations as a result of the extension of services to house-bound patients and careful survey and management of nursing home residents[16]. Reablement is concerned with helping people to get back some of the skills and confidence they may have lost through poor health, a disability or going into hospital or residential care[17].

Home care reablement is a short-term intervention that aims to maximise independent living skills, so people can remain at home for longer. The evidence so far strongly suggests that a period of home care reablement can reduce the subsequent use of home care services and that, for some people, these benefits may last for a year or more[18]. The Social Care Institute for Excellence has produced an overview of reablement, with case examples[19].

There are around 84, 000 unpaid carers in West Sussex (Census, 2011) and the number is set to grow. Caring however has a major detrimental impact on health and wellbeing.

| **Investment requirements** | **£30,154,000** |
|---|---|

[13] Transforming the delivery of health and social care: The case for fundamental change, Kings Fund 2012
[14] Benefits Realisation; Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care. Turning Point, February 2010
[15] Young, J & Clegg, A. (2010) Community-based specialist nurses for older people with long-term conditions in England. Journal of Clinical Gerentology and Geriatrics 1, 9-11
[16] Kaul, A., Bansal, M. & Bhandri, R. (2012) Interventions to prevent the hospitalisation of elderly patients: Quality care with cost benefits. Journal of American Geriatrics Society 60, S172-S173
[17] Shaping the future of care together Green paper 2009
[18]Glendinning, C. and Newbronner, E. (2008) The effectiveness of home care reablement - developing the evidence base, Journal of Integrated Care, 16, 4, 32-39.
[19] Reablement: implications for GPs and primary care Social Care Institute for Excellence 2012

**Impact of scheme**

Further information about how the BCF Plan impacts the patient outcomes is set out in section 2 b. This scheme will impact on the following overall outcomes:

- **B - Proportion of older people (65 and over) who are still at home after discharge from hospital into reablement or rehabilitation** – through improved multidisciplinary support and care coordination
- **C - Delayed transfers of care from Hospital per 100,000 population** – through improved access to health and social care services in the community
- **D - Reduction in emergency admissions** – through effective risk stratification of patients at risk of admission and developing a clear and shared care plan

**Feedback loop**

Given the diversity of the interventions within this scheme commissioners will establish specific performance arrangements with relevant providers all of which will link to this overarching set of outcomes.

- Reduction in the rate of reported excess winter deaths per 100,000 population
- Increase in the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into rehabilitation or reablement
- Reduction in the rate of delayed transfers of care from hospital per 100,000 population
- Increase in the number of older people utilising Telecare assistive technologies in West Sussex

The majority of data will be drawn from existing data returns. All interventions will also be subject to full evaluation at 1 year and if continued at 2 years.

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

- The development of integrated health and social care services to provide a joined up sub-acute pathway
- Full and transparent review of existing expenditure to enable appropriate joint commissioning of the single rehabilitation and reablement service
- Rehabilitation and reablement services will require excellent workforce planning to ensure staff skill-mix and clinical leadership delivers an effective model
- Development of Co-commissioning of Primary Care between CCGs and NHS England
- Interoperability of health and social care systems to support Telecare, Telehealth and other assistive technologies

**Lead**

| | |
|---|---|
| **BCF Working Group (Martin Parker)**<br>West Sussex Integration Sponsor Group (WSCC / CCG Commissioner and Acute, Community and Social Care Provider Group) with West Sussex County Council as Lead Commissioner for Domiciliary Care, Reablement and Carers Services | |
| **Key milestones 2015/16** | |
| Quarter 1 | To develop business plan for integrated sub-acute model and team(s) including public / staff / provider / GP engagement |
| Quarter 1 | Development of Telehealth pilots |
| Quarter 1 | Joint review and joint commissioning of Community Beds to support patient flow |
| Quarter 1 | SCT model for community beds in place & reporting in CWS |
| Quarter 1 | 2- 5 year plan for community beds |
| Quarter 1 | Agreed pathways for stroke |
| Quarter 1 | Integrated CBIT teams in place |
| Quarter 1 | Waste medicine campaign launched |
| Quarter 1 | EOLC improved pathways in place |
| Quarter 1 | Discharge to assess in place |
| Quarter 2 | West Sussex System agreement to integrated sub-acute model |
| Quarter 2 | West Sussex Carers Framework refresh (following engagement with public and providers) |
| Quarter 2 | Service changes operational |
| Quarter 2 | Integrated rehabilitation (OT) services development |
| Quarter 2 | Review of Carer Services in Acute Hospitals and Carers Health Team pilots |
| Quarter 2 | Joint commissioning of Social Care / CHC Care and Support At Home Maintaining Independence Services |
| Quarter 2 | On-going monitoring of Community Equipment Services and Assistive Technologies contracts |

| | |
|---|---|
| Quarter 3 | Joint commissioning of reablement services to cover health and social care |
| Quarter 3 | Development of integrated sub-acute model and team(s) including specifications |
| Quarter 3 | CWS 6 month evaluation of community bed model |
| Quarter 4 | CWS further changes to the model agreed and implemented |
| Quarter 4 | On-going review and development of Continuing Health Care Services |

**Scheme ref no.**

3

**Scheme name**

**Seven day working**

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

**To support providers to develop and deliver effective seven days services to improve outcomes for patients and redesign the discharge process to maintain patient flow.**

**Overview of the scheme**

Local health and social care partners have committed to delivering seven day working. This will ensure that the patient flows through the system and services become more settled and consistent, preventing increases in activity around certain times of the week and year having a detrimental impact on the system.

To enable this, commissioners will agree plans with health and social care providers to achieve progressive achievement of the standards defined in NHS Services, Seven Day Standards (Keogh, 2013). These plans will be embedded in contracts and will secure the priority achievement of 14 hour assessment by a hospital consultant and MDT working for all patients admitted to hospital. Full compliance will be achieved by March 2016.

Discharge processes will also be improved to ensure when patients are admitted to hospital their journey home and back to independence is facilitated effectively, and seven days a week, by establishing a clear system-wide discharge planning model. This model will align the range of services commissioned to the needs of the patient alongside an agreed set of standards and outcomes to be applied to all discharge pathways.

**The delivery chain**

<table>
<tr><th>Joint Commissioners</th><th>Providers</th></tr>
<tr><td rowspan="2">West Sussex County Council</td><td>West Sussex County Council<br><br>Social Work and reablement services</td></tr>
<tr><td>Independent sector providers<br><br>Care home services and other prevention services</td></tr>
</table>

| | |
|---|---|
| **NHS Horsham & Mid Sussex CCG**<br><br>Acting as lead commissioner on behalf of NHS Crawley CCG and NHS Coastal West Sussex CCG | **Sussex Community NHS Trust**<br><br>Community services supporting discharge and community hospital beds |
| **NHS Crawley CCG** | **Surrey and Sussex Healthcare NHS Trust**<br><br>Acute hospital services |
| **NHS Coastal West Sussex CCG**<br>Acting as lead commissioner on behalf of NHS Crawley CCG and NHS Horsham & Mid Sussex CCG for Sussex Partnership NHS Foundation Trust | **Western Sussex Hospitals NHS Foundation Trust**<br><br>Acute hospital services |
| | **Sussex Partnership NHS Foundation Trust**<br><br>Mental Health services |

**The evidence base**

**Seven day working**
The national review has highlighted significant variation in outcomes for patients admitted to hospitals at the weekend. This variation is seen in mortality rates, patient experience, and length of hospital stay and re-admission rates (Keogh, 2013).

**Discharge planning**
80% of patients admitted in an emergency with a length of stay over 2 weeks are over 65 (King's Fund, 2011) and structured discharge support can reduce the likelihood of readmission by 15% (Shepperd et al, 2010). It is particularly effective when patients are already known to community services. Focussing on this process has significant potential to reduce hospital bed use and cost.

There is a great deal of variation in the quality of health care offered throughout the week. An analysis of NHS inpatient data from 2009/10 reported that admission at the week-end was associated with an increased risk of mortality compared with those admitted on a weekday, ranging from an 11% increase in risk for those admitted on a Saturday to a 14% increased risk for those admitted on a Sunday when compared to patients admitted on a Wednesday[20]. Subsequent studies have supported this, with the finding that patients admitted as an acute medical emergency at the week-end had a 14% increased chance of mortality compared with those admitted on a week day[21]. Reasons for this disparity include variable staffing levels in hospitals at week-ends, a lack of consistent specialist services at week-ends, and a lack of specialist community and primary care services leading to more people on an end-of-life care pathway dying in hospital.

[20] Freemantle, N. et al. (2012). Weekend hospitalization and the additional risk of death: An analysis of inpatient data. Journal of the Royal Society of Medicine 105(2):74-84

[21] Bell D, Lambourne A, Percival F, Laverty AA, Ward DK (2013) Consultant Input in Acute Medical Admissions and Patient Outcomes in Hospitals in England: A Multivariate Analysis. PLoS ONE 8(4): e61476. doi:10.1371/journal.pone.0061476

It is recognised that both health and local government services will need to be included in the model of seven day services, including primary care, secondary care, community health services, mental health services, social care, housing and the voluntary sector. The BCF has been identified by the NHS Services, Seven Days a Week Forum, as an enabler to making seven day working a reality[22]. As a condition of accessing BCF funding, CCGs and local authorities will have to demonstrate that they are addressing a number of national conditions. These include seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends. Governance and standards are discussed in the Forum Evidence Base[23]

Examples of successful cross-agency 7 day working are showcased[24] under the main principles of admission prevention, early diagnosis and intervention, and early supported discharge. Further examples are listed in the Forum evidence base[23]. The end of life care strategy 2008[25] also emphasises the importance of integrated 7 day working to avoid unnecessary emergency admissions to hospital and enable more people at the end of their life to live and die in the place of their choice

| **Investment requirements** | **£2,700,000** |
|---|---|

**Impact of scheme**

Further information about how the BCF Plan impacts the patient outcomes is set out in section 2 b. This scheme will impact on the following overall outcomes:

- **B - Proportion of older people (65 and over) who are still at home after discharge from hospital into reablement or rehabilitation** – through improved multidisciplinary support and care coordination
- **C - Delayed transfers of care from Hospital per 100,000 population** – through improved access to health and social care services in the community 7 days per week
- **D - Reduction in emergency admissions** – through improved access to out of hospital services over the weekend

**Feedback loop**

Given the diversity of the providers that will be making changes to services within this scheme, commissioners will establish specific performance arrangements with providers all of which will link to this overarching set of outcomes.

- Reduction in the rate of delayed transfers of care from hospital per 100,000

[22] BOARD PAPER - NHS ENGLAND NHS Services, Seven Days a Week

[23] NHS Services, Seven Days a Week Forum Evidence base and clinical standards for the care and onward transfer of acute inpatients

[24] NHS Improving Quality, Equality for all - delivering safe care seven days a week - case studies 2012

[25] End of Life Care Strategy Promoting high quality care for all adults at the end of life Department of Health 2008

population
- Increase in discharges over the weekend which do not result in readmission within 28 days
- Reduction in mortality rate of patients admitted to hospital at the weekend
- Reduction in length of stay for patients admitted to hospital at the weekend

All data will be drawn from existing data returns.

All changes will also be subject to full evaluation, ensuring compliance with national seven day standards at March 2015 and March 2016.

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

- Commissioners being effective in securing agreements into provider contracts with regard to progressive compliance with seven day standards
- Collaborative working across all provider partners in the design of an agreed discharge process

**Lead**

**BCF Working Group (Dominic Elett)**
7 Day Working Group (WSCC / CCG Commissioner and acute, community and social care provider Group)

**Key milestones 2015/16**

| | |
|---|---|
| Quarter 1 | Set up 7 Day Working Group with appropriate commissioner, HR, Union and provider membership |
| Quarter 1 | Flexibility for 7 day working included in Commissioning Intentions and Provider Planning |
| Quarter 1 | Services meetings first set of clinical standards |
| Quarter 1 | Services meetings second set of clinical standards |
| Quarter 1 | CWS services begin meeting first wave of clinical standards as agreed with commissioners |
| Quarter 2 | Development of 7 Day Working HR Strategy including evidence review, public/staff/provider engagement, impact assessment and financial implications |
| Quarter 3 | Implementation of 7 Day Working HR Strategy |
| Quarter 4 | Review of 7 Day Working through on-going monitoring of delivery and outcomes |

| Scheme ref no. |
| --- |
| 4 |
| **Scheme name** |
| **Dementia services** |
| **What is the strategic objective of this scheme?** |
| **To develop dementia services so they can offer; increased crisis support; integrate further with physical health services; provide additional carer support and ensure timely and equitable access across West Sussex.** |
| **Overview of the scheme** |
| In recent years there has been significant progress in developing dementia services in West Sussex. Building on this work, commissioners will further enhance dementia crisis services to meet demand from the growing number of people living with dementia in West Sussex. However, effective reactive care is only one element of a new model for dementia care. There must also be more proactive support, dementia friendly communities and physical health services.<br><br>To deliver this the continued expansion of the Memory Assessment Service will support more people toward diagnosis and support with the offer of annual review. Commissioners will also work with acute hospitals to develop integrated shared care wards. In partnership with District and Borough Councils there will be more dementia friendly communities identified and developed enabling people living with dementia to remain living in their own community.<br><br>These are just some of the specific changes will support the delivery of our new West Sussex Dementia Strategy that will improve services and outcomes through changes services across the following themes:<br><br>• Prevention<br>• Recognising there is a problem<br>• Discovering the condition is dementia<br>• Living well with dementia<br>• Getting the right help at the right time<br>• Nearing the end of life<br>• Support to engage with research |
| **The delivery chain** |

| Joint Commissioners | Providers |
|---|---|
| **West Sussex County Council** | **West Sussex County Council**<br><br>Social Work services |
| | **District and Borough Councils**<br><br>Regarding development of dementia friendly communities |
| **NHS Horsham & Mid Sussex CCG**<br><br>Acting as lead commissioner on behalf of NHS Crawley CCG and NHS Coastal West Sussex CCG | **Sussex Community NHS Trust**<br><br>Community services supporting discharge and community hospital beds |
| **NHS Crawley CCG** | **Surrey and Sussex Healthcare NHS Trust**<br><br>Acute hospital services |
| **NHS Coastal West Sussex CCG**<br>Acting as lead commissioner on behalf of NHS Crawley CCG and NHS Horsham & Mid Sussex CCG for Sussex Partnership NHS Foundation Trust | **Western Sussex Hospitals NHS Foundation Trust**<br><br>Acute hospital services |
| | **Sussex Partnership NHS Foundation Trust**<br><br>Mental Health services |

**The evidence base**

**An aging population**
There are currently 13,000 people living in West Sussex with Dementia and this is set to grow by 14% by 2017 and by 26% by 2021, with an increased predicted associated social care cost of 25% over the same period.

**Dementia friendly communities**
Crawley has been designated as a dementia friendly community.

There are currently estimated to be over 13,000 people living with dementia in West Sussex; this is set to grow by 14% by 2017, with a further 26% increase by 2021. Of these, around 1,700 people are estimated to have severe dementia. Age has a clear relationship with both the severity of symptoms and the probability of living in a care institution. West Sussex has one of the oldest populations of any local authority in England and the number of older people is expected to grow as a proportion of the population year on year for the next 20 years, with particularly high growth in those aged over 90. Data in Jan 2013 estimated that 45% of those living with dementia had received a diagnosis and were on GP registers[26]. This figure is consistent with the figures quoted

[26] Dementia Framework West Sussex 2014-2019

in the NICE commissioning guidance on dementia, which suggests that around only half of people with dementia receive a diagnosis[27]. Early diagnosis allows people to plan, and to receive appropriate treatment and care earlier; this can potentially delay deterioration and prevent future crises. Increasing the number of people with an early diagnosis is an objective of the National Dementia Strategy[28], though it is recognised that this creates greater demand for services that support people with dementia.

A report by the Alzheimer's Society in 2009[29] suggested that people with dementia are occupying up to one quarter of hospital beds at any one time, that 42% of individuals aged over 70 with unplanned admission to an acute hospital have dementia, and that approximately half of carers indicated that being in hospital had a significant negative effect on general physical health and/or symptoms of dementia. A Birmingham-based study found that more people with dementia were admitted as emergency cases and that the proportion of patients admitted for dementia as their primary diagnosis was small[30]. Primary diagnoses included syncope (loss of consciousness) and collapse, bronchopneumonia, urinary tract infection and dehydration. This finding is supported by other studies[31] that found that 43% of admissions of people with dementia were for pneumonia and urinary tract infection.

The result of a study which elicited the views of an expert panel to prioritise ambulatory care sensitive conditions (ACSCs) and interventions for future research and implementation gave dementia top priority[32]. The proportion of admissions that could be avoided by provision of care outside hospital was the most important factor in deciding which conditions to prioritize. Access to rapid response nursing and social care at home, intermediate care beds and mental health crisis teams were identified as key interventions to reduce admissions.

| **Investment requirements** | **£1,500,000** |
|---|---|

**Impact of scheme**

Further information about how the BCF Plan impacts the patient outcomes is set out in section 2 b. This scheme will impact on the following overall outcomes:

- **A - Permanent admissions of older people (65 and over) to residential and nursing homes** – through supporting more people to live well in the community and reduce their risk of crisis
- **C - Delayed transfers of care from Hospital per 100,000 population** – through improved access to health and social care services in the community

[27] NICE commissioning guidance: Support for commissioning dementia care 2013

[28] Living Well With Dementia: a national dementia strategy. Department of Health 2009

[29] Counting the Cost: Caring for people with dementia on hospital wards. Alzheimer's Society 2009

[30] Natalwala, A., Potluri, R., Uppal, H. and Heun, R. (2008). Reasons for hospital admissions in dementia patients in Birmingham, UK, during 2002–2007. Dementia and Geriatric Cognitive Disorders, 26, 499–505

[31] Sampson, E., Blanchard, M.R., Jones, L. et al. (2009). Dementia in the acute hospital: prospective cohort study of prevalence and mortality. The British Journal of Psychiatry, 195, 61–66

[32] Sarah Purdy, Tom Griffin, Chris Salisbury and Debbie Sharp (2010) Prioritizing ambulatory care sensitive hospital admissions in England for research and intervention: a Delphi exercise. *Primary Health Care Research & Development* 2010; **11:** 41–50

- **D - Reduction in emergency admissions** – through effective risk stratification of patients at risk of admission and avoiding crisis
- **E - Improved patient and service user experience** – through supporting more patients to live healthily in dementia friendly communities
- **F - Local Metric – Estimated diagnosis rate for dementia** – through improved access to assessment services
-

**Feedback loop**

Given the diversity of the changes within this scheme, commissioners will establish specific performance arrangements with providers all of which will link to this overarching set of outcomes.

- Reduction in the rate of delayed transfers of care from hospital per 100,000 population
- Increase in dementia diagnosis rates
- Reduction in the rate of emergency admissions for patients living with dementia against the current 2014-15 baseline rate of emergency admission for patients living with dementia
    - Qualified by an absolute reduction in the number of emergency admissions for patients living with dementia
- Reduction in the rate of permanent care home placements following hospital admission for patients living with dementia
    - Qualified by an absolute reduction in the number of permanent care home placements for patients living with dementia

All data will be drawn from existing data returns. All changes will also be subject to full evaluation after 1 year.

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

- Collaborative working across all physical and mental health providers which ensures appropriate clinical governance and supervision of staff working in integrated services
- The joint and integrated commissioning of dementia services through co-production with both people with dementia and their carers and with the local providers of dementia services
- Implementing the wider strategies within the County wide Dementia Framework developed by a range of stakeholders and signed up to by health and social care commissioners, alongside these specific projects

**Lead**

**BCF Working Group (Tom Insley)**
Dementia Joint Commissioning Group (WSCC / CCG Commissioner and acute, community, mental h and 3rd sector provider group)

| Key milestones 2015/16 | |
|---|---|
| Quarter 1 | Dementia Shared Lives Pilot |
| Quarter 1 | Engagement with providers and 3rd sector for implementation of West Sussex Dementia Framework priorities |
| Quarter 1 | Commissioning of increased capacity in Dementia Crisis Service and Memory Assessment / Dementia Advisors service |
| Quarter 1 | Full implementation of enhanced crisis and support services |
| Quarter 2 | Working with community stakeholders to develop plans for expansion of Dementia Friendly Towns |
| Quarter 2 | Review of Dementia Shared Lives pilot |
| Quarter 4 | On-going review of Dementia Services |
| Quarter 4 | Establishment of further Dementia Friendly Towns |

| Scheme ref no. |
| --- |
| 5 |
| **Scheme name** |
| **Rapid Access and Intervention** |
| **What is the strategic objective of this scheme?** |
| **To develop urgent and emergency care services so they are able to offer rapid assessment and intervention to people in a health or social care crisis wherever it is safe to do so to reduce likelihood of hospital admission** |
| **Overview of the scheme** |
| Demand for urgent and emergency and crisis care and support services, and particularly acute hospital services, continues to rise both locally and nationally. However, many patients accessing these services could be better treated outside of hospital, either in primary or community care.<br><br>Commissioners will continue to invest in rapid access health and social care services in the community that offer a genuine alternative to hospital care and are able to effectively intervene and support patients through their acute or crisis episode. Local models already include; a single point of access, rapid assessment nursing and therapies teams, community geriatrics and GPs in some A&E departments. These are supported through the joint commissioning of services, for example equipment, that are able to respond rapidly to referrals.<br><br>Specific interventions include the Take Home & Support project where patients accessing urgent care services, and where safe to do so, are supported back into their own home and supported potentially avoiding the need for hospital admission on social grounds. Relative Support will also be improved at the point of crisis so that patients and their families are enabled to make informed decisions about their future health and care needs.<br><br>In addition Commissioners will lead local services through the national designation process for Major Emergency Centres and Emergency Centres from the current A&E model and to a more coordinated network of care.<br><br>Within Coastal West Sussex commissioners will also undertake a review of the current A&E model with a view to redesigning how access to and through A&E departments operates so that it is more integrated with primary care (both in and out of hours) and considers how to best offer an urgent treatment centre model. |

**The delivery chain**

| Joint Commissioners | Providers |
|---|---|
| **West Sussex County Council** | **West Sussex County Council**<br><br>Social Work services |
| **NHS Horsham & Mid Sussex CCG** | **Sussex Community NHS Trust**<br><br>Community urgent care services |
| **NHS Crawley CCG** | **Surrey and Sussex Healthcare NHS Trust**<br><br>Acute hospital services |
| | **Sussex Community NHS Trust**<br><br>Community urgent care services |
| **NHS Coastal West Sussex CCG** | **Western Sussex Hospitals NHS Foundation Trust**<br><br>Acute hospital services - Lead Provider for One Call One Team |
| | **Sussex Community NHS Trust**<br><br>Community urgent care services |

**The evidence base**

**Managing ambulatory care sensitive conditions**
Nationally over 15% of admissions are for potentially avoidable ambulatory care sensitive conditions (Tien et al, 2012). Older people are also more vulnerable to admission for these conditions but this can be addressed through improved interaction between primary, community secondary and social care (CQC, 2013).

**A&E demand**
A&E demand continues to rise toward unsustainable levels in part due to the trust the public have in the A&E model and the speed of access, with the vast majority being treated within 4 hours. Yet nationally, over 40% of people attending A&E require no treatment at all.

**Stroke services**
There is a growing evidence base that developing stronger stroke care services that are more networked and offer more specialised stroke care improves outcomes.

The East Midlands Academic Health Science Network conducted an evidence review of

rapid assessment and its effect on emergency admission, and concluded that evidence was mixed as to its efficacy[33]. The result of a study which elicited the views of an expert panel to prioritise ambulatory care sensitive conditions (ACSCs) and interventions for future research and implementation concluded the highest rated interventions involve the direct delivery of rapid access care in the community, and the highest ranked aspects were all related to improved access to alternatives to admission such as rapid response nursing and social care or intermediate care beds[34]. There is evidence that rapid access to geriatric clinics, as part of a system of care, reduced avoidable emergency geriatric admissions and shortened length of stay for all emergency geriatric admissions at the Royal Free Hospital[35], and the British Geriatrics Society suggests rapid access to assessment, such as the comprehensive geriatric assessment (CGA), is a necessary part of pathways of care alternative to hospital admission[36].

| **Investment requirements** | **£6,376,000** |
|---|---|

**Impact of scheme**

Further information about how the BCF Plan impacts the patient outcomes is set out in section 2 b. This scheme will impact on the following overall outcomes:

- **B - Proportion of older people (65 and over) who are still at home after discharge from hospital into reablement or rehabilitation** – through improved multidisciplinary support and care coordination
- **C - Delayed transfers of care from Hospital per 100,000 population** – through improved access to health and social care services in the community
- **D - Reduction in emergency admissions** – through rapid access to health and social care services in the community

**Feedback loop**

Given the diversity of the changes within this scheme, commissioners will establish specific performance arrangements with providers all of which will link to this overarching set of outcomes.

- Reduction in the rate of A&E attendance per 100,000 population
    - Qualified by an absolute reduction in A&E attendances
- Proportion of patients seen, treated and admitted or discharged within 4 hours is within national targets

[33] East Midlands Academic Health Science Network Evidence-based review: Rapid assessment community service and the prevention of emergency admissions for older people 2014

[34] Purdy, S., Griffin, T., Salisbury, C. & Sharp, D. 2010. Prioritizing ambulatory care sensitive hospital admissions in England for research and intervention: a Delphi exercise. Primary Health Care Research & Development 2010; 11: 41–50

[35] Wright, P.N., Tan, G., Iliffe, S. & Lee, D. (2013). The impact of a new emergency admission avoidance system for older people on length of stay and same-day discharges. Age and Ageing, 43(1):116–121.

[36] Acute Medical Care of Elderly People - British Geriatrics Society 2010

- Reduction in the rate of emergency admissions against the current 2014-15
- baseline rate of emergency admission per 100,000 population
- Reduction in the rate of delayed transfers of care from hospital per 100,000 population
- Delayed transfers of care remain below 3.5% bed days lost

All data will be drawn from existing data returns. All changes will also be subject to full evaluation after 1 year.

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

- Continued investment in existing Rapid Access and Intervention services
- Identifying and securing appropriate contract models to support any new arrangements
- Aligning changes to urgent and emergency care services with the A&E designation process

**Lead**

**BCF Working Group (Debra Wheeler)**
Horsham and Mid Sussex & Crawley CCG Systems Resilience Board (CCG / WSCC Commissioner and acute, community and social care provider group)

**Key milestones 2015/16**

| | |
|---|---|
| *Quarter 1* | *CWS contract in place reflecting lead provider arrangements for OCOT* |
| *Quarter 1* | *The wider admission avoidance potential of the CWS service scoped* |
| *Quarter 1* | *CWS new model designed and published in partnership with providers* |
| *Quarter 2* | *Elements of refined and enhanced CWS OCOT models in place* |
| *Quarter 2* | *Initial changes to CWS services implemented and reporting* |
| *Quarter 2* | Year of care training implemented in developing primary care (DPC) |
| *Quarter 2* | Care plans loaded (DPC) |
| *Quarter 2* | Rapid access heart clinics operational |
| *Quarter 3* | One Call One Team expansion completed |

| | |
|---|---|
| *Quarter 4* | *CWS  month evaluation of enhanced OCOT provision* |
| *Quarter 4* | *CWS 6 month evaluation of initial changes* |
| *Quarter 4* | *Implementation of majority of  CWS changes complete* |

| Scheme ref no. |
|---|
| 6 |
| **Scheme name** |
| **Improving quality in Care Homes** |
| **What is the strategic objective of this scheme?** |
| **To develop and implement a quality assurance and care governance framework for all care and nursing homes in West Sussex that ensures improved outcomes for those living in care and nursing homes including reducing their risk of hospital admission.** |
| **Overview of the scheme** |
| With a large and growing elderly population and an already significant care and nursing home (care home) market, managing the quality and outcomes of people living in care homes is becoming even more important.<br><br>Commissioners will work collectively to develop a quality assurance approach for care homes that ensures providers strengthen their leadership and management capabilities; their workforce skills and competencies through enhanced education and training offers that means fewer patients are unnecessarily admitted to hospital. The new process will be delivered through a multi-disciplinary team who will focus on the quality and safety of the places in which care is delivered. It will be enabled through a new market monitoring system called Firefly.<br><br>NHS commissioners will specifically ensure that medical cover for care homes is appropriate and aligned to this new model of quality improvement and assurance. This is to be enhanced by Care Home Matrons who also support homes when a patient has urgent care needs and provide longer term support and development to care home staff.<br><br>Medicines management in care homes has also been identified as an important area in reducing avoidable admission to hospital from care homes. Specialist Pharmacists will be commissioned to support homes with effective medicines management and ensuring appropriate medication reviews are undertaken. Evidence suggests this model can lead to reducing the risk of hospital admission for people living in care homes. |
| **The delivery chain** |

| Joint Commissioners | Providers |
|---|---|

| | |
|---|---|
| **West Sussex County Council** | **West Sussex County Council**<br><br>Social Care services<br><br>**Private Care Home providers**<br>Residential and Nursing home providers across West Sussex |
| **NHS Horsham & Mid Sussex CCG** | **Primary Care Providers**<br><br>Additional GP services and pharmacy services<br><br>**Sussex Community NHS Trust**<br><br>Community nursing |
| **NHS Crawley CCG** | **Primary Care Providers**<br><br>Additional GP services and pharmacy services |
| **NHS Coastal West Sussex CCG** | **Primary Care Providers**<br><br>Additional GP services and pharmacy services |

**The evidence base**

The care home population in West Sussex, (living in medical and care establishments) was 9058 at the time of the 2011 census, 1.12% of the population[37]. This is the second highest proportion of all counties in England; East Sussex has the highest proportion, with 1.41% of its population resident in care/nursing homes. Care homes can be a source of unnecessary hospital admissions; there have been a number of initiatives to reduce this. Some of these aim to enhance the skill of the care workers, and promote communication and co-operation between the care home and local healthcare providers.

One such initiative[38] introduced a pilot in north west Surrey aimed at reducing the number of emergency admissions to the trust from local nursing homes, by working in partnership to support staff in the homes and local GPs. There were monthly medical advisory meetings with GPs, access to a telephone advice line Mon-Fri 9am-5pm from a hospital consultant, provision of intravenous antibiotics and fluids on site, and facilitation

[37] West Sussex JSNA core dataset

[38] Lisk, R., et al., Geriatrician input into nursing homes reduces emergency hospital admissions. Arch. Gerontol. Geriatr. (2011)

of advance care planning at the end of life. A 35% reduction in hospital admissions was observed for 12 nursing homes once the pilot was rolled out.

An initiative in Bath and North East Somerset, involving the local authority and the primary care trust, introduced a dedicated team of to provide nursing and physiotherapy to the residents of three care homes[39]. The team also supported health and nursing training for designated staff within the homes. A number (between 81 and 197) of new admissions were averted, and a lesser number of early discharges were facilitated.

In east Surrey a community matron for care homes role was developed. These matrons assisted care home staff in developing their competence and confidence in managing their residents' care; a reduction in avoidable attendance/admissions and an improvement in care quality has been reported[40].

The adoption of co-ordination programmes such as the Gold Standards Framework (GSF), at the end of life, has been encouraged by the 2008 End of Life Care strategy[41]. The adoption of the GSF by a care/nursing home can result in significant reduction in numbers of hospital deaths and hospital admissions, fewer crises calls out of hours, and more documented advance care plans and DNARs forms[42].

The Kings Fund has listed ten priorities for commissioners[43]; one of these is medicines management. Up to 7% of hospital admissions are associated with adverse drug reaction[44], and these reactions are more common among vulnerable groups such as frail patients in care and nursing homes[45]

**Medicines Management**
A project run by North Staffordshire CCG showed that a clinical pharmacist review led to optimized therapy and also generated savings. Over a 12 month period 1271 patients were reviewed, leading to 1624 recommendations on treatment changes. GPs agreed with 96% of these recommendations. Of the changes made 50% led to medicines optimization, and an annual saving of £205,000 was seen.

| | |
|---|---|
| **Investment requirements** | **£1,079,000** |
| **Impact of scheme** | |

[39] Providing nursing support within residential care homes Joseph Rowntree Foundation 2008
[40] Burns, C. Nursing Times. 2013 Jan 15-21;109(1-2):23-5
[41] End of Life Care Strategy Promoting high quality care for all adults at the end of life Department of Health 2008
[42] Summary of Evidence for Gold Standards Framework Care Homes Training programme National GSF Centre August 2012
[43] The Kings Fund Transforming our health care system: Ten priorities for commissioners. 2013
[44] Pirmohamed M, James S, Meakin S, Green C, Scott A, Walley T, Farrar K, Park B, Breckenridge A (2004). 'Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients'. British Medical Journal, vol 329, pp 15–19
[45] Gurwitz J, Field T, Judge J (2005). 'The incidence of adverse drug events in two large academic long-term care facilities'. American Journal of Medicine, vol 188, no 3, pp 251–8.

Further information about how the BCF Plan impacts the patient outcomes is set out in section 2 b. This scheme will impact on the following overall outcomes:

- **C - Delayed transfers of care from Hospital per 100,000 population** – through improved access to health and social care services in the community which support care homes
- **D - Reduction in emergency admissions** – through improved support to care homes to avoid crisis where possible and use appropriate services when they do
- **E - Improved patient and service user experience** – through supporting care homes to offer excellent care and support to residents

**Feedback loop**

Given the diversity of the changes within this scheme, commissioners will establish specific performance arrangements with providers all of which will link to this overarching set of outcomes.

- Reduction in the rate of A&E attendance for people living in care homes
    - Qualified by an absolute reduction in A&E attendances for people living in care homes
- Reduction in the rate of emergency admissions for people living in care homes against the current 2014-15 baseline rate of emergency admission for people living in care homes
- Reduction in the rate of delayed transfers of care from hospital for people living in care homes

All data will be drawn from existing data return, additional data fields may be required in acute SuS data to identify those patients currently living in a care home. All changes will also be subject to full evaluation after 1 year.

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

- Identifying relevant best practice to support development of Quality Assurance and Care Governance Framework
- Current care home market being supported and able to respond to changes in the management of their contracts
- Meeting the Local Authority wider market management and quality assurance duties required under The Care Act

**Lead**

**BCF Working Group (Dominic Elett)**
Quality in Care Home Working Group (CCG / WSCC Commissioner and market provider group)

**Key milestones 2015/16**

| | |
|---|---|
| Quarter 1 | Establishment of Quality In Care Home Working Group |
| Quarter 1 | Engagement with care homes, acute providers, GPs and pharmacists and development of plans for improvement in quality in care homes |
| Quarter 1 | *Expansion of integrated response team* |
| Quarter 1 | *Delivering the dementia framework* |
| Quarter 2 | Development of proactive multi-disciplinary care quality support teams |
| Quarter 2 | Expansion of Care Home Matrons and use of technology to link with Geriatricians / GPs |
| Quarter 2 | Explore development of links with Pharmacists |
| Quarter 4 | Review pilots / schemes / new services developed |

| **Scheme ref no.** |
|---|
| 7 |
| **Scheme name** |
| **Care Act** |
| **What is the strategic objective of this scheme?** |
| **To fully implement the new duties for Local Authorities to be brought in under The Care Act.** |
| **Overview of the scheme** |
| Commissioners must meet the costs of implementing the new system to support the process changes the Care Bill requires as well as improving information, advice and support for carers. There will also be an additional and significant number of people living in West Sussex who may request support and guidance from social care when the Care Act comes into force in April 2015.<br><br>The Care Act also covers new duties that local Authorities will have for Carers, especially |

the duty to assess carers if it is felt there is a need for support. Carers will therefore be supported through a new county-wide Carers Support Service – a new open door model of carer support; an improved market for short breaks - giving greater choice to carers; improved access to support in acute settings at times of crisis; and the Carers Health Team, one of the first of its kind in England and who provide dedicated health and care support to carers preventing them from their own health deterioration.

Delivering these changes in partnership between the Local Authority and the CCGs is of fundamental importance if we are to ensure our health and social care system is placed on a sustainable, outcome focused, footing. This will require transformational change, particularly in relation to prevention and delaying care needs and will focus on the following:

- **Applying the Wellbeing principle** – we must always actively seek to improve that adults' wellbeing. This includes their physical, mental and emotional wellbeing
- **Prevention** – to ensure the provision of preventative services that help to prevent, delay or reduce the development of care and support needs
- **Information and advice** – to be available to all people in the local authority's area regardless of whether or not they have eligible care needs.
- **Market Shaping and Provider Failure** – places new duties on the Local Authority to facilitate and shape the market for adult care and support as a whole that is of high quality and personalised.
- **Integration** –promoting greater integration with NHS and other health related services.
- **Co-operation** – a general duty to cooperate between other Local Authorities and other relevant authorities
- **Cap on Care Costs** – establishes a limit on the amount that adults pay towards meeting the cost of their care needs within their life time.
- **Introduction of a national eligibility criteria** – likely to broaden the existing criteria in West Sussex
- **Carers** – places a duty on the local authority to undertake 'carer's assessments' on the basis of the appearance of a need for support.
- **Independent Advocacy** – an independent advocate will facilitate the involvement of a person in their assessment, support planning and review if they have substantial difficulty in being fully involved and there is no one appropriate to support them.
- **Person Centred Care and Supporting Planning and personal budgets** - now enshrined in law
- **Safeguarding** – puts Safeguarding Adult Boards and Serious Case reviews on to a statutory footing and places a duty on the local authority to carry out safeguarding enquiries.
- **Prisons** – the Local Authority must meet the care and support needs of people within prisons, including the provision of prevention, information and advice

**The delivery chain**

| Commissioner | Providers |
|---|---|
| **West Sussex County Council**<br>Working in partnership with CCGs, District and Borough Councils, and HMP | **West Sussex County Council**<br><br>Social Work services and care and nursing homes |
| | **Community and Voluntary Sector**<br><br>Providing support, advocacy and care services |
| | **Sussex Community NHS Trust**<br><br>Providing the Carers Health Team |

**The evidence base**

Analysis of the impact of the Care Act has indicted a significant cost pressure for the Local Authority. Resources will be required to deliver the requirements of the Care Act including the new national eligibility criteria and the cap of care costs as well as to support implementation and capital costs for new systems and processes.

It is estimated that, in west Sussex, the Care Act will, by 2017/18:
- increase the number of assessments carried out annually by between 10,000 and 13,000
- provide up to 6,200 carers assessments annually
- increase support planning for self funders and Local Authority funded people by between 1400 – 1900

| **Investment requirements** | **£2,017,000** |
|---|---|

**Impact of scheme**

The Care Act will lead to significant cost pressures for Local Authorities, including an increase in administration costs, for example setting up care accounts, monitoring spend, additional assessments and reviews, additional information, advice and advocacy, as well as an increase in overall care and support costs for individuals and their carers.

Further information about how the BCF Plan impacts the patient outcomes is set out in section 2 b. This scheme will impact on the following overall outcomes:

- **E - Improved patient and service user experience** – through supporting more people with care needs

**Feedback loop**

The impact of the Care Act will be monitored by WSCC on a monthly basis through its Adult Services Management Information systems

Given the wide ranging and diverse nature of the changes that will be required through the Care Act, commissioners are still developing, but will establish, specific performance arrangements with providers all of which will link to this overarching set of outcomes.

- In development

All changes will also be subject to on-going analysis and full evaluation after 1 year.

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

- Preparing systems, processes and services to be ready for implementation of the Care in April 2015 to avoid the potential for legal challenge from residents unable to benefit from the Care Act immediately once in force
- Well prepared communication plans to ensure that people are made aware of the true nature of the Care Act and the implications of it for them.
- Strong early analysis of the impact of the Care Act from April 2015

**Lead**

**BCF Working Group (Martin Parker)**
West Sussex County Council Care Act Implementation Group

**Key milestones 2015/16**

| | |
|---|---|
| Quarter 1 | Commissioning of Carers Assessments and Advocacy Services |
| Quarter 1 | Expansion of social care assessment capacity |
| Quarter 1 | Development of policies and process around fees and charges |
| Quarter 1 | Ensuring Wellbeing, Prevention, Integration, Co-operation, Person Centred Care and Making Safeguarding Personal principles become established in business as usual practices for all stakeholders |

| | |
|---|---|
| Quarter 1 | Ensure links and appropriate systems are developed with appropriate stakeholders around Market Shaping and Provider Failure |
| Quarter 1 | On-going communication with public and training of professional staff around impact and implications of the Care Act |
| Quarter 1 | *Carers support service fully operational* |
| Quarter 2 | Develop systems and practice to support delivery of Care Accounts |
| Quarter 4 | Review demand for social care and carers assessments, information and advice services, advocacy services and make appropriate amendments to services |

| Scheme ref no. |
|---|
| 8 |
| **Scheme name** |
| **Supporting integration – project support** |
| **What is the strategic objective of this scheme?** |
| **To secure additional resources to support the on-going planning and enable delivery of the West Sussex BCF plan, schemes and projects. This includes maximising the use of the skills and expertise already available and closely aligning and jointly managing projects where beneficial.** |
| **Overview of the scheme** |
| Such large-scale change will require significant investment of time, energy and staff to deliver in line with the ambitions across partners in West Sussex. This scheme will ensure that appropriate and proportionate project, programme and portfolio management approaches are utilised and staff are available to oversee the whole planning and delivery process.<br><br>This will be embodied in the establishment of a Programme Management Office (PMO) to specifically support the BCF schemes and projects. This will be linked to existing PMO type arrangements within organisations.<br><br>Resource's will also be made available to support projects themselves so that relevant expertise and cover is made available as required, as well as covering on-off costs of research, design and delivery. |
| **The delivery chain** |

| Joint Commissioners | Providers |
|---|---|
| **West Sussex County Council** | **N/A** |
| **NHS Crawley CCG** | |

| | |
|---|---|
| **NHS Horsham & Mid Sussex CCG** | |
| **NHS Coastal West Sussex CCG** | |

**The evidence base**

There is extensive evidence that recognised project, programme and portfolio management techniques can streamline and improve delivery of new capabilities and change (NHS Change Model, 2013). There is also evidence that appropriately trained and support staff within an established PMO function can further accelerate delivery and promote accountability and ownership.

| **Investment requirements** | **£226,000** |
|---|---|

**Impact of scheme**

This is an enabling scheme and will not be subject to monitoring of improved outcomes in isolation.

**Feedback loop**

This enabling scheme will be measured through the delivery of the other seven schemes and their constituent projects using the following metrics:

- The proportion of projects running on time (measured through achievement of agreed milestones)
- The proportion of projects delivering the measurable improvements set out in their project BCF Business Case
- The overall delivery of an absolute reduction in emergency admissions
- The overall delivery of an absolute reduction in permanent placements in care homes

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

- Agreement on the size structure of any centralised function and governance arrangements into partner organisations from any centralised function
- Agreement on the methodology and management techniques to be deployed for example PRINCE2, MSP, AGILE or a local bespoke model

| **Lead** | |
|---|---|
| BCF Joint Commissioning Sub Group | |
| **Key milestones 2015/16** | |
| Quarter 1 | Appoint permanent full time BCF Co-ordinator |
| Quarter 1 | Utilise knowledge experts to support implementation of transformation of system and integration of services as required |

# ANNEX 2 – Provider commentary
# 2A

| | |
|---|---|
| **Name of Health & Wellbeing Board** | West Sussex Health & Wellbeing board |
| **Name of Provider organisation** | **2 Western Sussex Hospitals NHS Foundation Trust** |
| **Name of Provider CEO** | Marianne Griffiths |
| **Signature (electronic or typed)** | |

**For HWB to populate:**

*The local Health and care economy is significantly challenged and is developing a range of plans which will deliver efficiencies across different budget areas. The BCF plans are not new or different and are completely embedded with all the CCG plans which have been discussed in a number of fora including local transformation board. The impact for providers will be in excess of 3.5% NEL admissions and will impact on more complex patient casemix and across other activity types. This is included in our discussions with providers on all our plans.*

| | | |
|---|---|---|
| **Total number of non-elective FFCEs in general & acute** | **2013/14 Outturn** | 43670 |
| | **2014/15 Plan** | 45347 |
| | **2015/16 Plan** | 40980 |
| | **14/15 Change compared to 13/14 outturn** | 3.84% |
| | **15/16 Change compared to planned 14/15 outturn** | -9.63% |
| | **How many non-elective admissions is the BCF planned to prevent in 14-15?** | 729 |
| | **How many non-elective admissions is the BCF planned to prevent in 15-16?** | 5045 |

**For Provider to populate:**

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

**2B**

| | |
|---|---|
| **Name of Health & Wellbeing Board** | West Sussex Health & Wellbeing board |
| **Name of Provider organisation** | **Surrey and Sussex Healthcare NHS Trust** |
| **Name of Provider CEO** | Michael Wilson |
| **Signature (electronic or typed)** | |

**For HWB to populate:**

*The local Health and care economy is significantly challenged and is developing a range of plans which will deliver efficiencies across different budget areas. The BCF plans are not new or different and are completely embedded with all the CCG plans which have been discussed in a number of fora including local transformation boards. The impact for providers will be in excess of 3.5% NEL admissions and will impact on more complex patient casemix and across other activity types. This is included in our discussions with providers on all our plans.*

| | | |
|---|---|---|
| **Total number of non-elective FFCEs in general & acute** | **2013/14 Outturn** | 15461 |
| | **2014/15 Plan** | 13651 |
| | **2015/16 Plan** | 11017 |
| | **14/15 Change compared to 13/14 outturn** | -11.70% |
| | **15/16 Change compared to planned 14/15 outturn** | -19.29% |
| | **How many non-elective admissions is the BCF planned to prevent in 14-15?** | 502.60 |
| | **How many non-elective admissions is the BCF planned to prevent in 15-16?** | 2634 |

**For Provider to populate:**

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

**2C**

| | |
|---|---|
| **Name of Health & Wellbeing Board** | West Sussex Health & Wellbeing board |
| **Name of Provider organisation** | **Sussex Community NHS Trust** |
| **Name of Provider CEO** | Paula Head |
| **Signature (electronic or typed)** | Agreed electronically. |

**For HWB to populate:**

*The local Health and care economy is significantly challenged and is developing a range of plans which will deliver efficiencies across different budget areas. The BCF plans are not new or different and are completely embedded with all the CCG plans which have been discussed in a number of fora including local transformation board. The impact for providers will be in excess of 3.5% NEL admissions and will impact on more complex patient casemix and across other activity types. This is included in our discussions with providers on all our plans.*

| | | |
|---|---|---|
| **Total number of non-elective FFCEs in general & acute** | **2013/14 Outturn** | 1580 |
| | **2014/15 Plan** | 1679 |
| | **2015/16 Plan** | 2495 |
| | **14/15 Change compared to 13/14 outturn** | 6.26% |
| | **15/16 Change compared to planned 14/15 outturn** | 48.61% |
| | **How many non-elective admissions is the BCF planned to prevent in 14-15?** | -82 |
| | **How many non-elective admissions is the BCF planned to prevent in 15-16?** | -816 |

**For Provider to populate:**

| | Question | Response |
|---|---|---|
| **1.** | **Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?** | At this stage we recognise the modelling that supports the assumptions on non-elective admissions reduction. We will need to understand in more detail the link between the assumptions in planned activity for our Trust in15/16 and the reduction in acute activity; along with the impact on our block contract to be fully confident in delivery |
| **2.** | **If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?** | |
| **3.** | **Can you confirm that you have considered the resultant implications on services provided by your organisation?** | We recognise the plans that are included in the submission and have considered the resultant implications on services provided by our organisation. |

**2D**

| | |
|---|---|
| **Name of Health & Wellbeing Board** | West Sussex Health & Wellbeing board |
| **Name of Provider organisation** | **Brighton & Sussex University Hospitals NHS trust** |
| **Name of Provider CEO** | Matthew Kershaw |
| **Signature (electronic or typed)** | Agreed electronically |

**For HWB to populate:**

*The local Health and care economy is significantly challenged and is developing a range of plans which will deliver efficiencies across different budget areas. The BCF plans are not new or different and are completely embedded with all the CCG plans which have been discussed in a number of fora including local transformation board. The impact for providers will be in excess of 3.5% NEL admissions and will impact on more complex patient casemix and across other activity types. This is included in our discussions with providers on all our plans.*

| | | |
|---|---|---|
| **Total number of non-elective FFCEs in general & acute** | **2013/14 Outturn** | 13096 |
| | **2014/15 Plan** | 13865 |
| | **2015/16 Plan** | 12337 |
| | **14/15 Change compared to 13/14 outturn** | 5.87% |
| | **15/16 Change compared to planned 14/15 outturn** | -11.02% |
| | **How many non-elective admissions is the BCF planned to prevent in 14-15?** | 569 |
| | **How many non-elective admissions is the BCF planned to prevent in 15-16?** | 1528 |

**For Provider to populate:**

| | Question | Response |
|---|---|---|
| **1.** | **Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?** | 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 on-going to validate the forecast out-turn position for 2014/15.<br><br>BSUH supports the principle and strategic intent of the West Sussex Better Care Plan. The Trust believes that the proposed BCF schemes are appropriate commissioning interventions that will improve quality and service user experience. If implemented according to plan, they will deliver significant reductions in acute activity, but as noted in the plan's risk log this is not straightforward and unprecedented reductions in acute demand from the patient cohorts targeted by the planned interventions are required to deliver the forecast.<br><br>Any agreement to include impacts relating to the BCF in 2015/16 contracts is subject to the further development of implementation plans as highlighted in our response to Q3 below. |

| | | |
|---|---|---|
| **2.** | **If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?** | *N/A* |
| **3.** | **Can you confirm that you have considered the resultant implications on services provided by your organisation?** | BSUH has been engaged during the development of the Better Care Plan via the Local Transformation Board and is committed to making all necessary efforts to support delivery of the BCF plans of Horsham and mid-Sussex CCG. The Trust considers that significant further detail is required in terms of implementation plans for providers to be clear about the changes they are required to make. The LTB offers an appropriate mechanism for the delivery and agreement of that detail.<br><br>The Trust assessed the likely impact of the BCF on its activity, income and expenditure as part of its five-year plan submission. HMSCCG projections for the impact of demand management in 2015/16 are in line with those projected by the Trust in its 20th June five-year plan submission. £370k relating to CWS CCG was not anticipated.<br><br>BSUH's overall clinical strategy relies on the release of bed capacity by the BCF. We are therefore fully supportive of the strategic intention set out and have significant strategic opportunities to utilise released capacity which will be a subject of discussions at future LTBs. |

**2E**

| | |
|---|---|
| **Name of Health & Wellbeing Board** | West Sussex Health & Wellbeing board |
| **Name of Provider organisation** | **South East Coast Ambulance NHS Foundation Trust** |
| **Name of Provider CEO** | Paul Sutton |
| **Signature (electronic or typed)** | |

**For HWB to populate:**

*The local Health and care economy is significantly challenged and is developing a range of plans which will deliver efficiencies across different budget areas. The BCF plans are not new or different and are completely embedded with all the CCG plans which have been discussed in a number of fora including local transformation board. The impact for providers will be in excess of 3.5% NEL admissions and will impact on more complex patient casemix and across other activity types. This is included in our discussions with providers on all our plans.*

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

**For Provider to populate:**

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

Annex 3

**Related documentation**

| Document or information title | Synopsis and links |
|---|---|
| Care and Support at home paper presented to the HWBB in January in January 2014 | Commissioning a single integrated (health and social care) domiciliary care framework. To incentivise providers to maintain independence, and work with all private market providers to promote the outcome of independence. |
| Between Hospital and Home" Our Strategy for Sub- Acute Care – July 2013 | The Strategy is owned by Coastal, Crawley and Horsham and Mid Sussex Clinical Commissioning Groups and West Sussex County Council.<br>Sub-Acute Care is defined as health and social care services for the population where in-hospital acute care is not the best way to provide care.<br>The document describes how we plan to develop health and social care services and should be understood by citizens, patients and their carers, by care professionals across West Sussex-irrespective of which organisation they work for and by other health and care organisations not directly involved in sub-acute care |
| Sharing Information to improve Patient Care (Sussex IT Integration) – 2.10.13 | This document summarises the functional requirements for IT Integration across Sussex and describes the current high level vision for of the technical architecture.<br>The related Strategic Outline Case (SOC) proposes the procurement of IT integration capability between health care providers, and between health and social care teams in Sussex to deliver improved outcomes for patients and to reduce hospital activity.<br>This work will be built upon to deliver the national condition around data sharing. |
| Therapies Review | Commissioned by proactive care to implement integrated therapies which include Occupational Therapy and Physiotherapy working for West Sussex County Council, Sussex Community Trust and in partner Acute Trusts |
| National Audit Intermediate Care 2013 – NHS Benchmarking | West Sussex contributed to the National Audit Intermediate Care 2013. This analysed data (which included Patient Reported Experience Measures –PREMs) for Intermediate Care and Local Authority Reablement Services to inform the development of national best practice. |
| Health and Wellbeing Strategy – Addendum June 2013 | This sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in 2014/15. |
| Partnership Agreement | The SASH health economy joint agreement between providers for whole system join up and change. |
| Proactively Caring. | Sussex-wide strategic paper |
| Section 75 agreements | Existing collaborative agreement across WSCC and the three West Sussex CCGs |
| Dementia Framework | Developing a Dementia framework document for health and social care |
| Personalisation Framework | To develop a Personalisation framework |

## Annex 4 – Key Milestones

| Scheme | Activity | 2014-15 | | | | | | 2015-16 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q3 | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| **Planning** | Better Care Fund Plan Published | | | | | | | | | | | | | | | | | | |
| | Commissioning Intentions published aligned to the BCF | | | | | | | | | | | | | | | | | | |
| | 8 Scheme Working Groups Established | | | | | | | | | | | | | | | | | | |
| | Wave 1 Projects Agreed For 8 Schemes | | | | | | | | | | | | | | | | | | |
| | Provider engagement on Wave 1 detailed delivery plans | | | | | | | | | | | | | | | | | | |
| | Public engagement on Wave 1 Projects | | | | | | | | | | | | | | | | | | |
| | Wave 2 Projects Agreed For 8 Schemes | | | | | | | | | | | | | | | | | | |
| | Provider engagement on Wave 2 detailed delivery plans | | | | | | | | | | | | | | | | | | |
| | Public engagement on Wave 2 Projects | | | | | | | | | | | | | | | | | | |
| | Contract negotiation and provider engagement starts | | | | | | | | | | | | | | | | | | |
| | Contract negotiation complete and contracts agreed | | | | | | | | | | | | | | | | | | |
| | West Sussex PMO Model Agreed | | | | | | | | | | | | | | | | | | |
| | Performance framework agreed for all 8 schemes by JSCG | | | | | | | | | | | | | | | | | | |
| | Update on BCF Planning to Health & Wellbeing Board | | | | | | | | | | | | | | | | | | |
| | Update on BCF Delivery Planning to Health & Wellbeing Board | | | | | | | | | | | | | | | | | | |
| **Delivery** | Wave 0 (Already Live) Projects Aligned to BCP Outcomes | | | | | | | | | | | | | | | | | | |
| | Wave 1 Projects Go Live | | | | | | | | | | | | | | | | | | |
| | Wave 2 Projects Go Live | | | | | | | | | | | | | | | | | | |

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|---|---|---|
| | West Sussex PMO Recruited/Established | |

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| **Payment for Performance** | Payment for Performance Assessment 1 – Q4 14/15 | |
| | Payment for Performance Assessment 2 – Q1 15/16 | |
| | Payment for Performance Assessment 3 – Q2 15/16 | |
| | Payment for Performance Assessment 4 – Q3 15/16 | |