Better Care Fund in West Sussex

The Better Care Fund is a new single, shared budget between health (NHS) and social care that is designed to bring about closer working to deliver better services for the population of West Sussex.

The aim is that it will support health and social care to transform local services; to concentrate on providing people with the right care, in the right place, at the right time; care that is planned and tailored to a person's individual needs; and that is delivered in partnership, to the highest possible standards.

Working to meet rising demand on health and social care

The NHS and social care faces its greatest challenge of recent times as our population increases, gets older, and people are living with many more, complex health conditions. This is already resulting in a rising demand for health and social care services, and is only going to continue. At the same time the organisations involved are facing a significant financial challenge to deliver more care, without an increase in funding.

The whole NHS and social care system needs to change to meet these rising demands, and it is clear that a joint approach is needed to join the services closer together and develop joint ways of providing the right care for people, in the right place, reducing duplication, and working more effectively.

Bringing health and social care closer together means focusing on care, just as much as treatment, and working proactively to plan the right support for people to live as well as possible in their communities, prevent them from becoming unwell and to help them to recover when they do become unwell. Doing this effectively will mean that more people will be able to remain at home for longer, be cared for in their own home – or closer to home, and will be supported to live as independently as possible for as long as they are able.

Delivering this change

This commitment to working closer together is already underway between health and social care organisations in West Sussex. New ways of working are already being developed such as Proactive Care, and the NHS and West Sussex County Council already work together on areas such as mental health, continuing healthcare, and services for children with complex health needs.

However, we need to do more. The Better Care Fund requires the three NHS clinical commissioning groups in West Sussex and social care through West Sussex County Council to set out how they are going to work more effectively together, in partnership with current and future service providers, and how this collaborative approach will result in improvements to care for local residents.

It is important to acknowledge that the Better Care Fund is not new or additional money, it is about using existing budgets but spending them differently, in a joined-up coordinated way.

The three clinical commissioning groups in West Sussex and the County Council will remain accountable for the funds, but the way the money is spent will be overseen by a collaborative group, reporting to the individual statutory bodies, and the county's Health and Wellbeing Board.

Overall, the money to support this joint work is around £29.5m this year (2014/15) and will rise to £58m in 2015/16.

What will the Better Care Fund be spent on?

Among key areas of spend are:-

- **Proactive Care** – further developing our new way of caring for people with complex health and social care needs (see www.westsussex.gov.uk/proactivecare), which brings together NHS and social care professionals into joined-up teams to ensure that people get the right support at the right time and from the right care professional.
- **Sub-Acute care and Domiciliary care –** a focus on the care and support provided to people outside of acute hospitals, including rehabilitation services, to improve the care and support provided to people in their own homes.
- **Seven-day working** – to explore how high quality health and care services can be available seven days a week to ensure that people can receive the best possible care whether on a weekday or weekend, and they don't stay in hospital any longer than they need.
- **Dementia care** – improving and extending local services and support for people living with dementia and their carers, including increasing the number of people receiving an early diagnosis, further developing the support available following diagnosis, and extending crisis support for people with dementia and their loved ones.
- **Improving the quality of care in care homes –** working with local nursing and care homes to build on the strengths of what is available locally, and how this can be developed for local residents.
- **The Care Bill –** the Care Bill will introduce a range of new duties for the County Council and these will need to be prepared for, including new rights for carers, a cap on care costs, and a need for better information, advice and advocacy.

Fundamentally, the Better Care Fund will be used for genuine transformation of the health and social care system in West Sussex to ensure we can provide high quality care now and for future generations.

Working with our partners and local community

It is absolutely key that the CCGs and the County Council work alongside our partners, stakeholders, and the local community to continue to develop and co-design these plans so that we can provide the best possible outcomes for local residents.

We are committed to involving and engaging our partners, the voluntary sector, and the public, and over the forthcoming weeks and months there will be a range of opportunities to find out more about the Better Care Fund, the need for transformation, and how groups and individuals can work with us to further shape these plans.

More information

For more details about the Better Care Fund arrangements see below to view the Better Care Fund Plan.

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:	**Approved at Extraordinary HWBB meeting on 27 March 2014**
Date submitted:	**4.4.2014**
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

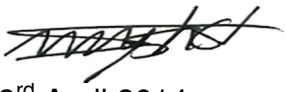
NHS Horsham and Mid Sussex Clinical Commissioning Group

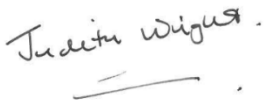
NHS Coastal West Sussex Clinical Commissioning Group

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Coastal West Sussex Clinical Commissioning Group
By	Dr Katie Armstrong
Position	Clinical Chief Officer
Date	 3rd April 2014

Signed on behalf of the Clinical Commissioning Group	Crawley Clinical Commissioning Group
By	Dr Amit Bhargava
Position	Chief Clinical Officer
Date	 3rd April 2014

Signed on behalf of the Clinical Commissioning Group	Horsham and Mid Sussex Clinical Commissioning Group
By	Sue Braysher
Position	Chief Officer
Date	 3rd April 2014

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	 2nd April 2014

Signed on behalf of the Health and Wellbeing Board	West Sussex Health and Wellbeing Board
By	Christine Field
Position	Chair of Health and Wellbeing Board

Date	 2nd April 2014

Context

This document has been developed by the three Clinical Commissioning Groups (CCGs) and West Sussex County Council, which aims to maximise the opportunities presented by the Better Care Fund (BCF). It outlines the overarching strategic direction and the agreed schemes It remains work in progress as the detailed implementation is worked through and the governance of this is explained further in this submission.

Collaboration and partnership working have been key to the mutual success of our joint work over recent years. A clear example of this is evidenced in our Joint Commissioning arrangements, which involve a joint budget of over £360m.

In moving forward, we believe that the Better Care Fund should be used for genuine transformation of the health and social care system in West Sussex, not simply to plug a gap in the social care or health budgets resulting from increasing demand or budget reductions. This transformation means consistently providing people with the right care, in the right place, at the right time; care that is planned and tailored to individual capabilities and needs; that is delivered in partnership, to the highest possible standards.

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.

1) PLAN ENGAGEMENT BACKGROUND

Service provider engagement

It will be essential for commissioning organisations to engage from the outset with all providers, both NHS and social care. Our goals will be to develop a shared view of the future shape of services; assess the future capacity requirements across our system; and to develop a set of key principles which help support the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for local providers are set out clearly for our Health and Wellbeing Board and that their agreement for the deployment of the fund includes agreement to the service change consequences.

Due to the timescales for the submission of the Better Care Fund plan, existing health and social care provider consultations have fed into the

development of the plan. 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 Better Care Fund and discussing their role within it. In addition the first submission of the Better Care Fund templates has been shared with them. The joint commissioners have stressed that the Better Care Fund 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.
- The joint 'Sub-Acute Review' with West Sussex County Council included provider consultation as part of the evidence review.
- The development of the Proactive Care programme consulted in the development of and includes providers within the sponsor group.

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

Primary Care (in their provider capacity) has been involved in the education programme which has included development and sharing of plans.
There has also been wide stakeholder input into the development of the Horsham and Mid Sussex (HMS) Infrastructure and Wellbeing Plan which is ongoing and will involve a second phase of stakeholder engagement and public consultation

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 workstreams.

As the disabled facilities grant funding is included in the Better Care Fund allocation, West Sussex District and Borough Councils have been engaged in planning for the BCF through regular meetings with West Sussex County Council and as members of the health and wellbeing board.

Patient, service user and public engagement

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.

West Sussex County Council, Public Health and Adult Services commissioning intentions have extensive scrutiny through the Select Committees, Cabinet and the Health and Wellbeing Board. The Select Committees and HWBB are public meetings. CCG plans are scrutinised through select committee, HWBB, their membership and through patient involvement fora.

Membership of the HWBB includes representation from the voluntary sector. In addition the CCG public launch events included an explanation of CCG planning and existing plans and how people could get involved.
At service level development, patient engagement and patient experience have been key drivers of the agreed service models e.g. Pro-Active Care, Urgent Care services, long-term conditions programme, dementia services and the maternity programme.
The CCGs also have formal sub committees of their Governing Bodies where patient voices are sought. (In Horsham/mid Sussex and Crawley CCGs, this is the Commissioning Patient Reference Group (CPRG) whilst in Coastal West Sussex it is the Patient Reference Panel (PRP.) These groups are seen to be key in the continual review and refinement of plans.

In addition, Coastal West Sussex CCG has embarked on a wide-ranging public engagement plan, entitled “Let’s talk”, supporting a range of initiatives promoting public engagement. Let’s Talk, is the CCG response to ’A Call to Action’ (2013). It isn’t a one off exercise – it is how patients and clinicians and healthcare professionals can continuously engage and communicate about the changes needed and the changes they want for the local NHS. Let’s Talk involves a whole range of approaches from events through to online communications; it reaches out into local communities to systematically gather insights and ideas, as well as concerns about care and services that will directly inform commissioning and planning.

2) VISION AND SCHEMES

Vision for health and care services

The HWBB December 2013 Away Day, considered some of the future vision of what services may look like.

The developing vision for 2018/19 is a shift from reactive to proactive care. There will be community based services centring on groups of GP practices, working alongside joint Health and Social care Multi-disciplinary teams as well as co-located specialist services. Connected information systems ensure a smoother journey for the patient through health and social care systems and patients/customers will have received treatment or care earlier in their condition or problem.

For the County Council this means that the outcomes fit with the Council's ambitions and be a key part of the transformation programme for Later Life led by the Director of Public Health, Commissioner for Health and Social Care services. It is the West Sussex County Council's Cabinets ambition that

people in West Sussex Age with Confidence. Local models be developed that that are built on the demography, needs analysis and local priorities and outcomes based on these.

At its most simple, the vision is for an approach that is more integrated; is designed around the needs of local people; that offers compassionate care that works and is here for us today and for future generations. This vision puts patients/customers at the centre of all that we do; it is what will guide us over the next five years. We have written the vision from a patients/customers perspective, your perspective, as the best measure of our success will be what local people experience and say about their health and social care in 2019. We want you to be able to say;

- I have one number that I call when I become unwell and need advice or care
- I have access to a choice of timely and responsive services which meet my needs
- I have one person who helps organise all of the care that I need to keep me well
- I feel listened to and involved with decisions about my care
- I feel safe and confident that I will be well looked after
- I know that I will be cared for at home for as long as possible

Aims and objectives

Here in West Sussex the Better Care Fund aims to be the catalyst to ;

1. Changing the model of Care

Where possible care will be provided at home or closer to home. Individuals will access appropriate care in settings outside of the traditional acute hospital setting. This change to out of hospital care requires more resources being used to provide care and support at home, in GP surgeries and in other local facilities.

2. Supporting Older People and those with Long term Conditions

The model will focus on pro-active management to meet individual's needs; promoting and enabling self-care and improving access to support. Making services more integrated so that care is better coordinated and the system is less complex and providing information, advice and treatment at the right time and right place. Developing and extending care closer to home to relieve pressure on emergency services, allowing services to focus on highest need.

3. Integration of Health and Social Care

Over the next five years community healthcare and social care teams will work together in an increasingly integrated way, with single assessments for

health and social care and rapid and effective joint responses to identified needs, provided in and around the home.

The West Sussex County Council cabinet have agreed Commissioning Intentions over the next four years that will meet the requirements of the care bill and be sustainable to meet the needs across communities, responding to demographic pressures. A key part of this working is the development of integrated working with health partners. This shall include the development of a joint commissioning plan which shall set out the overall objects and outcomes required of an integrated model for health and social care. Services for older people and adults with Long Term Conditions will be included as part of a model for an integrated service with health.

These aims and objectives shall be monitored against existing national measures and a locally agreed measure which are overseen by the HWBB. As we develop details of our Health and Social Care Integration programme we will also develop the measures of success. This will be developed with patients, carers and service providers to evaluate our progress over the next two years.

Proposed BCF metrics are as follows;

Metric	Current Baseline	April 2015	Oct 2015	Current status/Narrative
A Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population	670.00	n/a	653.00	West Sussex baseline shows as being in the worst quartile. The level of ambition set is to improve by at least one quartile.
B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement or rehabilitation (Outcome ambition 4)	89.86%	n/a	89.86%	West Sussex is in the highest quartile for current achievement. In view of the growing and ageing population our level of ambition is to maintain top quartile position which is a significant challenge in real terms.
C Delayed transfers of care from Hospital per 100,000 population (average per month)	409.16	349.67	315	Baseline data shows west sussex in the 4th quartile. The quartile ranges are wide and the ambition is to improve by 1 quartile by June 2015, maintaining baseline level for December 2014. This is ambitious given that most recent trends show an upward trend.
D Avoidable emergency admissions (composite measure) (Outcome ambition 3 and Quality Premium)	1521.61	1389.56	1258.83	CCG rates vary but there is an extremely wide confidence interval. West Sussex is in the best quartile nationally and our level of ambition is to remain here, recognising that quartile boundaries will change. This is suitably challenging as an

				objective because of the predicted population growth and ageing population.
E Patient and service User experience	West Sussex proposes using the national measure when developed			
F Local Measure estimated Diagnosis rate for dementia See below for trajectories	*The Local Measure needs to be confirmed by the HWBB. It is proposed to use measure 2.6i 'Estimated diagnosis rate for people with dementia' as the most appropriate local measure. This aligns completely with the agreed Joint Health and Wellbeing Strategy, is already an established measure and completely supports integration of local services.*			

CCG	Current	Target 14-15	Target 15-16
Crawley	62%	65%	70%
HMS	52%	55%	65%
CWS	49%	55%	65%
West Sussex combined		55%	65%

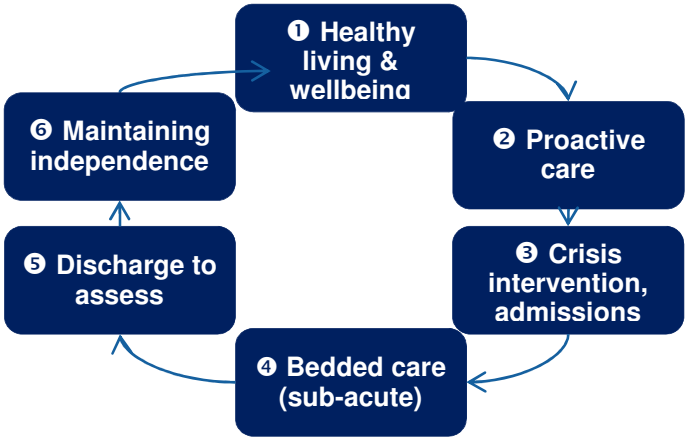
Description of planned changes

It is recognised that delivering our vision will require significant change across the whole of our current health and social care provider landscape.

Commissioning partners will agree an initial two year programme, including deployment of NHS Support for Social Care in 2014/15. This plan will be part of a five-year strategy for local health and care services from 2015 which is co-designed with patients, clients and carers; looks beyond immediate short-term pressures; and rests upon a shared vision of what future local services should look like. The additional investment in 2014/15 and 2015/16 will need to:

- support the redeployment of funds from existing NHS services;
- protect adult care services;
- target the resources to best effect; and
- manage the service change consequences.

The 'Six box model' of sub acute Care (Care between Hospital and Home – see diagram below) provides the key strategic framework and alignment for the investment of BCF pooled budgets. This is appropriate due to the joint ownership of the review and the jointly worked up plans.



In 2013/14, the spend on BCF (social care fund) & reablement, carers & grants within West Sussex totals £29.7m (see table below). This included £5.3m carried forward from the previous financial year which is non recurrent funding.

The transfer from Health to the Better Care Fund is due to increase by £2.7m in 2014/15 (funded centrally) and a further £30.6m in 2015/16 (to be found from existing CCG spend). These increases will be funded from a range of service/contract reductions within Community and Acute services. The impact is currently shown against the three main acute providers in order to highlight both the potential scale of change and which providers need to be included in the risk share agreement.

Re-ablement funding remains at £4m, within an indicative national allocation of £4m, over the period.

The model assumes that existing initiatives will continue to be funded from the BCF for the period to 2015/16. Future levels of funding required for re-ablement activity will be determined within the BCF pool, as service priorities are developed.

Carers funding from CCGs is shown as increasing to £1.8m from 2014/15, reflecting the national allocation percentage. However, this is subject to separate discussions and the final BCF will reflect the outcome.

The total capital allocation is estimated at £5.4m in 2014/15 and 2015/16, including £3.6m for the disabled facilities grant and £1.8m for the social care capital grant.
The CCGs and WSCC will need to work with Districts and Boroughs to confirm expenditure plans.

The table 1 below summaries the sources of the Better Care Fund.

Table 1

	2013/14	2014/15	2015/16
	£000	£000	£000
Health transfer to social Care / Better Care Fund 2013/14	11,900	12,271	12,271
Health transfer to social Care / Better Care Fund 2014/15		2,870	2,753
Health transfer to social Care / Better Care Fund 2015/16			30,653
Reablement	3,967	4,097	4,097
Carers	1,511	1,776	1,776
Disabilities Facilities Grant	3,592	3,592	3,592
Social Care Capital Grant	1,776	1,812	1,839
Cfwd from 12/13	5,325		
Other (WSCC Carers) (Above BCF Minimum)	1,595	1,628	1,628
Total Sources	29,666	28,046	58,609

The Better Care Fund notified in the allocations guidance is £56,981. The difference of £1,628 is the funding from WSCC for carers shown above, which is in addition to the BCF minimum

The amount that is included in the pay-for-performance element is £14.9m, and is therefore contingent in part on planning and performance in 2014/15 and in part on achieving specified goals in 2015/16.

High Level deployment of Better Care Funds

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 Better Care Fund 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 will be maintained in 2015/16, subject to evidence of effective outcomes. This includes an assumed £5.1m for schemes within social care, which are intended to act as a stepping stone to 2015/16.

Table 2 below shows the high level deployment of the funds. Although there is the appearance of a significant increase in funding against schemes 2 to 6, part of this will be the means through which £16.5m of protection is provided for social care.

Table 2

	NHSFSC	BCF
	14/15	15/16
	£000	£000
Proactive Care evolving to Community Based integrated Teams	10,009	15,584
Sub Acute, domicillary care, reablement and prevention	2,071	10,108
Seven day working	489	3,026
Dementia	489	3,026
Rapid Access/Intervention	1,466	9,082
Improving Quality in Care Homes	391	2,421
Care Bill Implementation		2,017
Programme Support/ Supporting integration	226	413
Reablement	*	4,097
Carers	*	1,776
Disabilities Facilities Grant	*	3,592
Social Care Capital Grant	*	1,839
WSCC Carers	*	1,628
Total	15,141	58,609

The following brief scheme descriptions outline the agreed shared areas of work. Built into these programmes will be delivery of the national conditions of protecting Social Care, seven day working, Accountable lead professional for integrated packages of care and better data sharing. Further work on detailed business cases will be undertaken. Further work on the Care Bill implementation figures to be confirmed.

Scheme 1: **Proactive Care – Evolving to Community Based Integrated Teams**
Description: During 2014-15: Integrated multidisciplinary teams providing holistic care to identified patients, utilising risk stratification. Full roll out and evaluation of existing schemes in 2014/15. Local differences in implementation in Coastal West Sussex and the north of the county reflecting identified population needs. The joint commissioners recognise that 2014-15 provides the stepping stone to wider system transformation and the scale of our ambitions for community based integrated teams requires the evolution and development of proactive care to reflect a greatly increased integration of health and social care into a wider model ready for 2015/16. This will facilitate a joint approach to Assessment and person centred Care Planning and include working with community and social care providers to develop the delivery models and care pathways required to keep people well and in their own homes. Development of primary care providers in line with the implementation of the Better Care Fund initiatives in order to ensure a truly integrated / joined up model of care. This includes the implementation of the accountable GP to improve the quality of care for older people and those with complex needs. See also joint assessment and accountable lead professional in Section 3

(pages 21 and 22). The £5 per head for commissioning additional services which will support the accountable GP will be integral to the community based integrated teams. It should be noted that funding to primary care clinicians to act as the accountable GP comes from different funding sources and is not included in the assumptions for this scheme.
Outcomes and Metrics Holistic person centred services enabling more patients to be kept well and independent in their own homes. National metric A, B, D, E and F.

Scheme 2: **Sub-Acute Care, Domiciliary Care, Reablement and Prevention**
Description: Review existing services and commission a single integrated health and social care rehabilitation and reablement service. Commencing with the review and joint commissioning of care and support at home, through which health and social care currently invest an estimated £26million per annum in West Sussex. The future commissioning of care and support at home seeks to ensure efficient, high quality, safe services, supporting customers with complex needs in their own homes. Reference to also be given to the Sub- Acute Review recommendations and review of Therapies Services. Primary Prevention is a key part of the holistic approach to reducing demand for health and care services by enabling people to enjoy healthy and active life within their communities. The West Sussex Older demographic profile will mean focussing preventative services on: • Investing in winter preparedness to reduce excess winter deaths • Ensuring we get housing right to support people to stay in their own homes • Preventing social isolation and loneliness to help maintain independence • Fall prevention which includes strength and balance training, home hazard assessment and intervention, vision assessment and medication review.
Outcomes and Metrics Streamlined service providing improved outcomes for patients and service efficiencies for health and social care. Impacts national metrics B and C

Scheme 3: **Seven Day working**
Description: To ensure the effective delivery of seven day services to support discharge. It will review current working (with acute hospital and community trusts), identify gaps in provision, evaluate and develop recommendations and costings to deliver this. It shall consider the development of a Human Resources Strategy and market development for care providers. Seven Day working is outlined further in section 3 (page 19) below.
Outcomes and Metrics Evaluated recommendations for model for 2015/16 implementation. Addresses the BCF national condition for 7 day working.

Scheme 4: **Dementia Strategy**

Description: : Ensure equity of access across the county and explore 24/7 access to urgent care services. Include programme change for increased dementia crisis team resource and integrated working and ensure availability of post diagnosis support services for patients diagnosed prior to the implementation of memory assessment services (MAS).
Build on mental health integration work within CCG's through the proactive and urgent care programmes.

Provide additional support for carers of people with dementia with greater access to advice, information, support and respite, including pilot to extend 'Shared lives' to people with dementia (where people stay on a short or long term basis in the homes of local paid carers).

Support whole system development of community based care, coherent pathways and appropriate resource allocation for integrated mental health and dementia care

The focus of development in 2014 – 2015 will be:

- Development of new joint commissioning strategy for dementia
- Further development of dementia friendly communities, following and building on the success of Crawley
- Focus on improving and extending crisis support to people with dementia and their carers including an increase in resource within the teams.
- Continuation of projects to integrate specialist dementia support into urgent and proactive care
- Continued focus on increasing diagnosis rate and ensuring post diagnostic support is available to everyone diagnosed with dementia, irrespective of whether they were diagnosed before the implementation of the MAS, with the offer an annual review.
- Further development of integrated shared care wards in acute hospitals

Outcomes and Metrics
Consistent provision of rapid response services as well as community based services integrated with health to provide parity of esteem. Deliver the HWBB agreed priority as well as metrics A,C,D and E. Impacts local metric F

Increasing % of people diagnosed with dementia and in receipt of support

Dementia diagnosis trajectory – identified as local BCF metric

CCG	Current	Target 14-15	Target 15-16
Crawley	62%	65%	70%
HMS	52%	55%	65%
CWS	49%	55%	65%
West Sussex combined		55%	65%

Scheme 5: **Rapid Access /Intervention**
Description: Review existing services and ensure that they are able to respond in a timely manner to prevent escalation of care in the context of a single integrated health and social care rehabilitation and re-ablement service. Utilise review of therapies recommendations. This scheme links very closely with community based integrated care and provides a resource and service option that is available to teams to provide identified joint care plans. These will support reductions in hospital admissions and avoid delays in discharge from more intensive services.
Outcomes and Metrics Streamlined service providing improved outcomes for patients and customers and service efficiencies for health and social care. Impacts national metrics B and C

Scheme 6: **Improving Quality in Care Homes**
Description: Overlapping with Scheme 2, 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 market. The QA approach will focus on strengthening providers' leadership and management capabilities, skills and workforce issues and enhance the current offer of education, training and support for care home staff. A digital QA and market intelligence software will be introduced to allow improved multi- disciplinary information sharing. Medical cover for care home patients will be strengthened and specialist equipment service enhanced.
Outcomes and Metrics: Fewer avoidable admissions from care homes and delayed transfers of care. National metrics C, D and E

Scheme 7 – Care Bill
Description; The Care Bill will introduce a range of new duties for the County Council beginning in April 2015. These include a cap on care costs for people with eligible social care needs (which will apply from April 2016) together with new rights for carers. Government has undertaken to provide additional funding in line with new burdens principles to ensure that this does not transfer a cost to the local taxpayer. £185m of that funding is included within the Better Care Fund and is designed to meet elements of the consequential expenditure, such as new entitlements for carers and systems changes. It also intended to be a source of funding for better information, advice, advocacy and safeguarding. The additional number of people who will become eligible for funded social care in West Sussex cannot yet be stated with any degree of certainty.

Nevertheless, the size of the self-funding market in West Sussex suggests that this will be a figure that will be measured in terms of thousands of people, so the funding allocated for Care Bill implementation in 2015/16 reflects the supplementary guidance issued by NHS England on 24 February. As a result £2m is earmarked for revenue costs, which is proportionate to the £135m allocated nationally. In addition funding will be made available from the Social Care Capital Grant to cover the cost of system changes that will be necessary. In both those cases the commitment will be subject to on-going review and refinement as the impact of the Care Bill across the whole system becomes more apparent, in particular on the point of entry to residential care for self-funders. Of equal importance is the expectation that the additional investment in carers and in information, advice and advocacy will support plans to enhance preventative services. This, in turn, should allow social care to play a greater role in reducing demand for acute services.
Outcomes and metrics Metrics will measure the early impact of those changes that will apply from April 2015 and the readiness of the County Council for the wider changes that will take effect from April 2016

Scheme 8: **Supporting Integration – Project Support (enabling programme)**
Description: 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 movements towards better functional integration.
Outcomes and Metrics: Supported transformational change that meets the objectives of health and social care commissioners.

Remaining schemes Reablement, Carers, Disabilities facilities Grant, Social Care Capital Grant and WSCC carers funds
As outlined in Table 2, the Reablement, Carers, Disabilities facilities Grant and Social Care Capital Grant, are not listed in the above boxes but all provide additional funding streams to the Better Care Fund. Furthermore the WSCC carers fund is an additional funding source from WSCC into the Better Care Fund. These schemes will be integrated into the ongoing work programmes, ensuring that there is no duplication and that over time the funds are deployed in support of the system change being implemented.
Outcomes and Metrics: Supported transformational change that meets the objectives of health and social care commissioners

Implications for the Acute Sector and Other Providers

Our vision for the future requires whole system change, including how we commission from our providers, the relationships our providers have with their

patients and customers and how the providers interact with each other. The resultant pattern of integrated care will mean evolutionary, albeit significant, change across our current health and social care landscape. The initiatives introduced over recent years, e.g. Proactive care, One call, one team, provide an invaluable platform on which to build. Together, we have begun to realise the benefits of these approaches and we are committed to enhancing these further.

As we become more successful in our approach, we anticipate emergency activity in hospitals being reduced, with planned care in hospitals also being reduced through the provision of alternative community- based services. Together, we will manage the ingress and egress from acute hospital care, resulting in us minimising delays in transfer of care, reduced pressures on our A&E departments and ensure that people are helped to regain their independence after episodes of ill-health as quickly as possible.

“Between Hospital and Home” is the pan-CCG and County Council strategy for Sub- Acute Care, produced in July 2013. 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 and this document describes how we plan to develop health and social care services.

Our approach to integrated care includes both physical and mental health care. Working with our providers, we see the future involving further integration between the work of community mental health teams and their counterparts in community and social care. In turn, we envisage mental health specialists being able to further support GPs and their patients in a similar way to physical health specialists.

Supporting the “parity of esteem for Mental Health” and “Mental Health is Everyone’s Business” agenda, our approach will be to ensure that patients with an urgent mental health need receive an equally responsive and consistent service comparable to urgent physical health care.
In addition, our approach will also support the integration of greater psychological support in long term conditions pathways.
The focus for mental health also includes people who have very complex presentations, often including substance misuse difficulties, domestic violence histories, and poor engagement with services

In order to realise these ambitions, we require the expert input of our provider colleagues in further reshaping the provision landscape. This may involve them working more collaboratively with each other, or perhaps in joint ventures to deliver integrated care. In addition, we have a collective responsibility for the broader stewardship of the local health and social care economy – ensuring sustainability of provision in the short, medium and longer term.

We are committed to working with our provider colleagues to plan the viable and sustainable transition to which we all aspire.

Where significant changes are both required and viable, we will aim to move quickly to new models of care. In other areas, it may be that a phased approach is required as we manage the transition.

Across west Sussex, we have a variety of forums in which we work closely with our provider colleagues e.g. Urgent care or transformation boards. We will build on these inherited models as we work through the finer detail of our plans with provider colleagues.

Impact on NHS Service Delivery targets

15% reduction in hospital emergency activity. If required savings do not materialise, Impact on NHS service delivery targets will be:

- Increased breaches in A&E targets
- Increased delayed transfers of Care
- Increased excess bed days

Further work is being undertaken to describe more fully the reductions in activity.

Governance

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. The overarching governance for BCF will be provided by the Joint Strategic Commissioning Group with all four partners signing off funding allocation and detailed business cases. For 2014/15 NHS Funding for social care will be deployed in line with existing governance processes subject to discussion 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 Better Care Fund 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.

Reporting to the Health and Wellbeing board, the Joint Commissioning Strategy Group (JCSG) is comprised of key executives from the County Council and the three CCGs. Augmented by separate accountability to their respective governing bodies, the JCSG provides the forum for the four parties to agree their approach to joint commissioning, integrated approaches to care and the Better Care Fund.

The JCSG will be supported through:

- Local Transformation Boards/Urgent Care Boards
- Internal commissioner governance processes

- Engagement through existing patient and public fora

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 oversight and sign off for the Better Care Fund template part 1 and 2.
As part of this framework, the November 2013, HWBB meeting, delegated authority to the Joint Commissioning Strategy Group (JCSG) so that they may lead on discussions about the allocation and evaluation of Better Care Funds and subsequently present to the HWBB for approval.
The Joint Commissioning Strategy Group (JCSG) brings together senior personnel from West Sussex Clinical Commissioning Groups (CCG's) and the County Council (WSCC). Whilst there are separate governance and accountability arrangements at individual organisational levels, the JCSG has a high level overview of the major projects that are jointly commissioned. The JCSG is not separately accountable, other than through the accountabilities of individual members to their host organisations. A key agreed principle is that the Better Care Fund provides an opportunity and leverage for change but should not be dealt with outside of the whole system context.

3) NATIONAL CONDITIONS

Protecting social care services

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 Better Care Fund agenda, including staffing costs and service models 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 national threshold for **eligibility** is based on new criteria that will increase the entitlement of support for individuals, and introduce the new duty to ensure the **wellbeing** of individuals.

Adults' 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 both care at home and where necessary, care and nursing home placements , and an integrated approach to end of life care.

Funding will be allocated to ensure the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not eligible for Fair Access to Care Services. It is recognised that they may need to be sustained if not increased within the funding allocations for 14/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Bill requires additional assessments to be undertaken for people who did not previously access Social Services.

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.

7 day services to support discharge

The Health and Social care system in West Sussex has a strategic commitment to providing seven day working. 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 8) and recognises the importance of seven day working.

To ensure the effective delivery of this work there will be a scoping exercise undertaken to identify gaps in provision, review current working, evaluate and develop recommendations and costings to deliver this by ensuring social workers and therapists are operational seven days a week. This work shall require consideration to be given to the Acute Hospital Trusts – availability of equipment, pharmacy services, patient transport and therapies seven day a week. The scoping exercise shall also consider the development of a Human Resource strategy and market development for care providers.

The objective of seven day a week working is to maintain the patient flow through acute and community hospital beds. It will also enable the restarting of packages of care. This project shall be evaluated, utilising a skilled professional in Adult Social Care (allocating specific funding for their time), who shall identify the best fit for the social work resource both in the Acute and Community Hospital settings, identify blockages to timely discharge and gaps in service provision and make recommendations to address these matters.

We are working with Health and Social Care providers to agree an implementation plan towards achieving progressive whole system compliance with the NHS Services, Seven Days a Week report set out by Sir Bruce Keogh in December 2013. Contracts established with all of our providers will specifically set out conditions to ensure that the ten clinical standards supporting Seven Day Working will be achieved over the next 2 years. In 2014/15 commissioning organisations will secure contracts which,

- Establish a clear priority for the achievement of the standard for 14 hour assessment by a consultant and MDT working for patients admitted to hospital
- Introduce a system wide governance framework for 7 day working
- Require clear evidence that providers are working towards full compliance by 31 March 2016
- Establish routine and community services seven days a week to provide an integrated system with urgent and emergency services

Data sharing

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 therefore plan to undertake 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 our Proactive Care teams and our One Call-One Team service. 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.

In West Sussex County Council the NHS number is not currently being used as a primary identifier, however we are committed to using it in principle and are in the process of populating our Social Care datasets with NHS numbers to support the Proactive Care projects. These projects for Coastal CCG and Crawley and Horsham and Mid Sussex CCG's have been a driver for the development of streamlining data use and the "Sharing Information to Improve Patient Care" document is referenced in the related documentation.

West Sussex County Council is committed to using open APIs and standards. The Proactive Care project 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. There are well developed Information Governance arrangements in place supported by the Commissioning Support Unit (CSU).

The CCG and West Sussex County Council are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Joint assessment and accountable lead professional

West Sussex embraces the philosophy of a joint assessment and lead professional. This will be utilised when the needs of the customer/ patient require it. 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 (and as expanded to community based integrated teams from 15/16 onwards). 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 ensuring that a clinician is leading the development of a care plan for patient/customer; that the care plan is personalised to the patient/customer; and that the patient/customer is able to

influence and control the care that is provided. GPs will be supported in doing this through the services developed as part of developing community based integrated teams, 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 high risk of admission is within a multidisciplinary team that consists of health and social care professionals and also includes mental health input. 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 approach to risk stratification that we use 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. The segment of population that we prioritise in the proactive care model is 65 -85% risk of admission.

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.

CWS CCG have agreed with clinical leads and with the local Lead Provider for Proactive Care, to review and develop care plans for 30 patients per month per practice who are identified by risk stratification which over the year will amount to approximately 4% of the population as whole.

CWS CCG is working with its local lead provider to establish a refreshed service delivery model for Proactive Care. This will be based on research commissioned by the CCH which indicates that the optimum rate of return for BCF investment comes from a focus on the high and medium risk population. In terms of numbers this is estimated at 11,400 people.

There are seasonal variations and as can be expected at any given time there are patients that will enter, remain or leave this segment. However as the health and social care system moves to greater integration 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.

RISKS

Risks have been rated using the following scale:

- High
- Medium
- Low

Risk	Risk rating	Mitigating Actions
Better Care Fund plans not achieved due to providers not being able to mobilise workforce and capability	High	Develop an Integrated workforce plan
Ensure that funded schemes do not lead to an increase in the number of admissions to residential and care homes as this goes against the personalisation agenda and the savings that the local authority has set.	High	Effective market management of care and support to ensure that other models of provision available. Robust monitoring of statistics through existing mechanisms and through joint PMO arrangements.
Manage the risk on the CCG's of sustaining services where some hospital trusts face significant financial challenges and the Better Care Fund puts additional pressure on this.	High	New models of provision to deliver a reduction in hospital activity.
Failure of the Better Care Fund to protect Adult Social Care	High	Ensure scheme developments, enable substitution of reduction in Adult Social Care services.
Failure to deliver on the Better Care Fund national conditions	Medium	Robust monitoring of BCF submission by the JCSG and HWBB.
In delivering 7 day a week social care services to support discharge, avoid the continual high cost spend on agency social work staff as this limits the number of staff hours being utilised as they are poor value for money.	Medium	Through longer term planning, recruit social work staff on fixed term/ permanent contracts
There is a risk that the CCG 13/14 out turn position means a greater level of NHS savings required than already planned for giving greater pressure on services and budgets	Low	Strong financial management Deployment of contingency funds Development of additional QIPP schemes
There is a risk that 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.	Medium	NHS England to ensure that effective systems/ staff skills in place to deliver system change.

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. 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. 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. 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. 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