Changes in Health and Social Care - Briefing August 2015

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Background

Since 2013 there have been some important legislative changes made to health and social care which aim to transform the way it is delivered. The core values of 'wellbeing' alongside 'whole person' care will have an impact on the ways both the statutory and voluntary and community sector (VCS) work and will offer new opportunities for collaboration.

These changes have both national and local implications and there are several local initiatives which aim to deliver a more integrated model of care. This information briefing aims to provide a summary of all of these changes and how they relate to each other as well as outline opportunities for the VCS.

Community Works has been funded to get involved in and run activities to enable the VCS to contribute to health and social care integration plans. If you would like to be part of this work please get in touch with our Project Leader, Tess Craven, on: 01273 234023 or tess@bhcommunityworks.org.uk

The Care Act

The Care Act 2014 aims to consolidate numerous social care laws and provide a more coherent approach to adult social care, offering clear and fair support. It also treats carers as equal to the person they care for – putting them at the centre of the law and on the same legal footing;

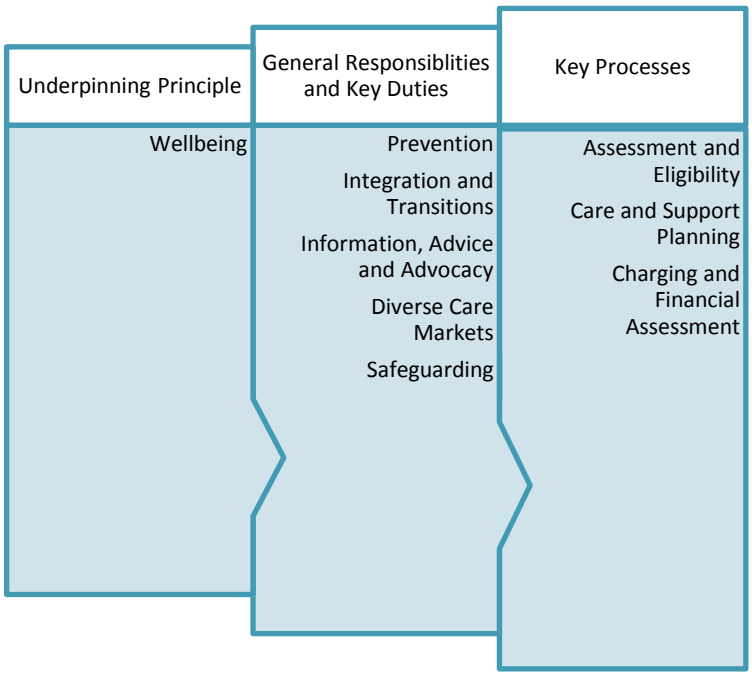
"Until now it's been almost impossible for people who need care, carers, and even those who manage the care system, to understand how the previous law affecting them worked. Over nearly 70 years it has been added to again and again and is out of date and confusing.

The Care Act has created a single, modern law that makes it clear what kind of care people should expect." **Former Care Minister Norman Lamb** [1]

Underpinning the Care Act is the general principle of **wellbeing** – this is a broad concept and statutory guidance relates it to the following nine areas:

- Personal dignity (including treatment of the individual with respect)
- Physical and mental health and emotional well-being
- Protection from abuse and neglect
- Control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided)
- Participation in work, education, training or recreation
- Social and economic well-being
- Domestic, family and personal relationships
- Suitability of living accommodation
- The individual's contribution to society.

This principle is intended to establish what the Law Commission called a '*single unifying purpose around which adult social care is organised*' and is the foundation from which the general responsibilities, duties and responsibilities arise.



General Responsibilities and Key Duties:

- Prevention – The local authority will provide or arrange for the provision of services, facilities or resources which will prevent, reduce or delay the need for care or support for adults or carers

[1] https://www.gov.uk/government/speeches/norman-lamb-mental-and-physical-health-one-agenda-conference

- Integration – The local authority has a statutory duty to collaborate with partners across the public sector to promote wellbeing and improve the care of adults in need of care and carers in its area
- Information, Advice and Advocacy – The local authority must establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers. This must include independent financial advice and advice on choice and types of care. Independent advocacy must also be available if a person needs it to be able to participate in and understand the care and support system
- Diverse Care Markets - In order to ensure that people are able to access care and support services to meet their needs, there must be a range of high quality services in every area. Local authorities have a critical role to play in building and managing the local market of services for the benefit of all local people allowing them to make the best choice to satisfy their own needs and preferences
- Safeguarding - A new statutory framework protects adults from neglect and abuse. Safeguarding adults' boards will be set up in every area

Key Processes:

- Assessment and Eligibility - Anybody, including a carer, who appears to need care or support is entitled to an assessment, regardless of financial contact with the council. The assessment must focus on outcomes important to the individual. Any needs currently being met by a carer should still be included in the assessment. The local authority must then apply a national eligibility threshold to determine whether the individual has eligible needs [2]
- Care and Support Planning - A local authority must help a person decide resources through an assessment. This assessment forms the base of the support plan which outlines how eligible needs will be met and must be reviewed regularly.
- Charging and Financial Assessment - At the moment there is no limit to what care and support can cost; this means that people with very high care needs may have to pay a significant amount towards care. The decision about the proposed 'cap on care costs' which might mean no one will have to pay more than £72,000 towards the care element of the costs of meeting their eligible needs in their lifetime has now been delayed until April 2020.[3]

The Care Act in Brighton and Hove

Locally, the way the Care Act is being enacted is still in development. Brighton and Hove City Council (BHCC) are in the process of reviewing and improving all of their information, both online and leaflets. The My Life portal (www.mylifebh.org.uk/) has been launched to meet some of the information and advice requirements within the Act. My Life gives access to both local and national information and aims to help people with a health condition or a social care need, their families and carers, to find the information they require to help with everyday living.[4]

[2] http://www.skillsforcare.org.uk/Document-library/Standards/Care-Act/learning-and-development/introduction-and-overview/care-act-overview-fact-sheet.pdf
[3] http://www.local.gov.uk/web/guest/care-support-reform/-/journal_content/56/10180/7436797/ARTICLE
[4] http://www.mylifebh.org.uk/

The way face to face advice, information and advocacy will be delivered is being reviewed. BHCC are using national modelling to anticipate demand and with regards to advocacy they are in discussions with current VCS providers around demand, Care Act requirements and capacity to respond. Guidance suggests that local authorities develop and implement a plan with regard to their information and advice services and it offers a framework for this based on 4 key elements:

- engagement and coproduction with stakeholders
- mapping the range of information, advice and advocacy services available
- coordination with other statutory bodies with an interest in care and support
- reviewing the effectiveness of the service.

The VCS already has significant expertise and knowledge in the delivery of information, advice and advocacy and a proven track record of meeting people's needs effectively in these areas. This will be an area where the VCS could potentially develop its service offer.

Better Care

In August 2013 the Government announced "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities"[5]. As **The Care Act** places a clear duty on local authorities to integrate with health services in order to promote the wellbeing of adults and improve the quality of care they receive and as such, it places Better Care on a statutory basis.

The vision for Better Care is to provide 'whole person care' which promotes independence. In Brighton, BHCC and the CCG are working closely together to develop a new model of proactive care for **frail** people which aims to reduce hospital admissions and deliver home and community services where possible. Rather than focusing on age alone, Brighton and Hove have taken a broader definition of 'frailty' as 'a state of high vulnerability for adverse health outcomes'. This wider definition could include:

- People with dementia
- People who are homeless
- People who are housebound
- People with multiple long term conditions
- People at end of life
- Care home residents

The decision to broaden the definition of frailty is linked to the city's distinctive demographics

- A marked lower proportion of children
- A much higher proportion of people aged 16-64 years
- A lower proportion of those aged 65-74

[5] NHS England and Local Government Association (2014) Statement on the health and social care Integration Transformation Fund, London: NHS England and Local Government Association, [online] Available at: http://www.england.nhs.uk/wp-content/uploads/2013/08/itf-aug13.pdf [accessed 1 May 2014]

This is also coupled with a very diverse set of needs: high levels of substance misuse (alcohol & drugs), high levels of mental ill-health and increasing levels of homelessness[6].

How will Better Care be achieved?

In order for the policy to succeed there are a number of conditions which are required[7]:

Understanding the needs of the frail population and designing effective service models – both now and in the future

- An emphasis on reabling care, including the use of assistive technology to support people to maximise their independence
- Individuals being empowered to direct and personalise their care and support based on their individual needs
- GP Practices at the heart of co-ordinating a person's care with support from a multi-disciplinary cross sector team
- The independent care sector and the local VCS working as active partners in service delivery
- Care that is co-ordinated in a single place to ensure service users and carers only need to tell their story once
- Care co-ordinators taking responsibility for active co-ordination of care for a full range of support (from lifestyle support to acute care)
- Service users and their carers being listened to and driving the model of care
- More people supported in community settings
- Access to professional support 24/7

There is a programme structure which supports all of the work being done within Better Care with 4 main delivery work streams with specific objectives (see Appendix 2 for the full Better Care Structure):

- Integrated Delivery – This work stream is aimed at designing and commissioning high quality and integrated primary and community services – an example of this work is transformation of primary care (see page 7) and the creation of multi-disciplinary teams within GP clusters – the purpose of which are to bring together communities of practice based professionals around GP practice populations to focus on care for those most vulnerable. The teams are drawn from physical and mental health services, social care, third sector providers, GP practices and pharmacies.
- Personalisation – The purpose of this work stream is to maximise the availability of personalised services that promote independence and enable people to fulfil their potential. An example of this is the pilot project of personal health budgets (PHB's) a personal health budget is an amount of money to support patients identified health and wellbeing needs and aims is to give people with long-term conditions and disabilities greater choice and control over the healthcare and support they receive.

[6] Brighton and Hove Clinical Commissioning Group (2013) Better Care Fund planning template – part 1, Brighton: Brighton and Hove Clinical Commissioning Group

[7] Brighton and Hove Clinical Commissioning Group and Brighton and Hove City Council (2013) Better Care plan: integrated care Briefing paper, Brighton: Brighton and Hove Clinical Commissioning Group and Brighton and Hove City Council

Personal health budgets work in a similar way to the personal budgets that many people are already using to manage and pay for their social care.

- Protecting Social Care – This work stream looks at ensuring that the changes to service provision required by the Care Act form part of an integrated health and social care service, focused on prevention and the needs of individual customers.
- Keeping People Well – This work stream is still in development but the projects attached to it will be aimed at supporting the key outcomes defined in this piece of work as; supporting people to be as independent as possible, reducing isolation and keeping people well and healthy for as long as possible

Challenges in developing integrated working

Better Care offers a significant opportunity to improve care and improve outcomes. However, there are some important challenges to be taken into consideration in developing more integrated care:

- The need for experienced and skilled staff
- Organisations having the administrative and developmental capacity to change. This is particularly acute in the VCS where this is often little or no funding to cover core costs
- Keeping monitoring and reporting requirements simple and proportionate
- Raising awareness of available services from every sector
- Managing any resistance to change
- Addressing cultural differences across provider organisations
- Considering all of the relevant stakeholders
- The challenges of sharing records/data/systems across organisations and sectors
- Thinking about how the pilots can be measured to ensure success

The role of the voluntary and community sector

The VCS already has significant expertise and knowledge around 'whole person care' and can work with partners to co-design models of care that will engage with and meet people's aspirations and needs. Additional VCS contribution and potential could include:

- Empowering local people to be informed and have access to effective care
- Providing peer support and mentoring
- Helping identify and combat social isolation
- Improving local knowledge about changing needs and gaps in services
- Improving quality of practice
- Improving joint working between providers
- Developing stronger, more sustainable services for the future
- Engaging vulnerable and disadvantaged people
- Adding social value and acting on the wider determinants of frailty
- Bringing in extra resource

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The Health and Wellbeing Board (HWB)

The Health and Wellbeing Board is a partnership body bringing together councillors, senior council officers, GP commissioners and local people to plan for health, public health and adult and children's social care services across the city. In April 2013 the Health and Wellbeing Board became a statutory body, with duties including:

- Agreeing a local Joint Health and Wellbeing **Strategy** – setting out the Health and Wellbeing Board's priorities for the city
- Publishing the local Joint Strategic Needs Assessment (JSNA) – setting out local health and social care requirements and assets
- Ensuring that health and social care commissioning is based on local needs
- Ensuring that local people are encouraged to take a full part in decision-making about local services [8]

It is also their responsibility to promote co-working across local health and social care services and as such it oversees the work around **Better Care**.

The Joint Health and Wellbeing Strategy (JHWS)

One of the duties of the HWB is to agree a local Joint Health and Wellbeing Strategy. This sets out the priorities for the City and in Brighton and Hove it focuses on five high priority areas where evidence shows that there is a significant need for better outcomes and where more effective partnership working could deliver real measureable improvement for local people.

The five priorities in Brighton and Hove are:

- Cancer and access to cancer screening
- Dementia
- Emotional health and wellbeing (including mental health)
- Healthy weight and good nutrition
- Smoking

This focused approach means that not all areas and priorities are included within it – this has been done to avoid duplication with other strategies or partnerships already working successfully. The five priorities chosen share some significant common properties and it is hoped that "improving outcomes in each of the areas may involve some similar strategies". [9]

The body of the strategy explores each of the five areas, describing the nature of the issue, outlining local services and including where work is already being done and where it can be

[8] http://www.brighton-hove.gov.uk/content/council-and-democracy/councillors-and-committees/health-and-wellbeing-board

[9] http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/Joint%20Health%20and%20Wellbeing%20Strategy.pdf

done better. As with **The Care Act** and **Better Care** the focus is fundamentally on the importance of partnerships in creating better outcomes for local people.

The Transformation of Primary Care

An important part of the way that Better Care will be delivered is through the transformation of primary care. Through this new approach GP practices will work together in **clusters;** these clusters are groups of between 4 and 11 practices in similar geographic areas working together to improve health and wellbeing outcomes of their patient population (for a map of how the clusters will be organised please see Appendix 3) Working together they will undertake work in:

- Risk Profiling
- Care Planning
- Medicines Management
- Social Isolation

These clusters will be delivering a more **proactive** form of care – this is a move away from medicalised models of care which ensure that the person is at the centre of their care, with a **multidisciplinary team** wrapped around them. This team will consist of health and social care professionals and potentially the voluntary and community and/or private sector organisations and will co-ordinate care around the holistic needs of the individual. There will be a greater focus on reducing preventable premature mortality by taking a proactive approach to identifying patients at risk and working together to help reduce that risk and keep people as healthy as possible. This model will begin to roll out in September 2015 although timescales are still in development.

In line with conditions set within Better Care, primary care will move towards a 7 day a week offer with extended opening hours. Currently this system is being trialled by the EPiC project (supported by the Prime Minister's Challenge fund which is aimed at improving primary care in the NHS). This way of working will become mainstreamed with the rollout of the clusters.

Locally Commissioned Services (LCS) will provide the overall direction of travel for primary care transformation. This way of allocating funds moves away from top-down approaches and involves GP practices in assessing local needs, helping to identify local priorities, and proposing new care pathways. LCS's also enable GP commissioners and practice managers to engage patients in the commissioning process and to use the **PPG's** to discuss commissioning issues.

Patient Participation Groups (PPGs)

Many GP surgeries in Brighton and Hove already have, or are in the process of developing a PPG to encourage and enable patients to have a say in and help make decisions about how their GP surgery is run. In the future PPGs will also be involved in the processes for buying health services provided by their practice. There is a facilitated city wide PPG network where members can share their experience and learn from each other as well as make sure they can hear about and be active in citywide health developments.

Since April 2015, it is a requirement that every surgery in the city has a PPG, with each surgery's group working and involving patients in a variety of ways as the groups evolve and develop. Involvement may vary and might include helping to conduct surveys, planning changes to GP buildings, reviewing systems in the surgery, organising health talks for patients and reviewing and increasing information provided by the surgery.

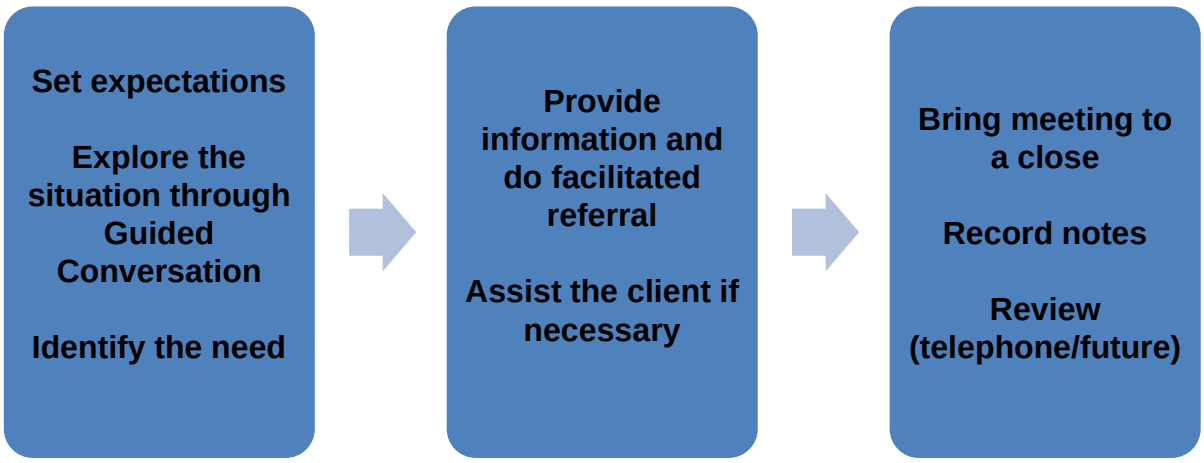
The CCG will also engage with PPG members as they develop their plans for buying health services and implementing changes to services. The CCG's plans on how they will interact with PPGs and other engagement structures in the city are being looked at as part of their ongoing engagement review.

Some PPGs will meet in their local surgery, and others may communicate by email and not meet formally, others may want to run small events and join others in their cluster group to promote healthy activities and community resources in their area. To join a PPG all you have to do is ask at your surgery and they will let you know how the group works there and when future meetings are and how they operate. How PPG's will work at a cluster level is still to be defined, although cluster 'boards' have been considered.

Community Navigation – An Integrated Working Case Study

Community Navigation is delivered by a collaborative partnership between Brighton and Hove Age UK, Brighton and Hove Impetus and Brighton and Hove Integrated Care Service (BICS). Community navigation is delivered by a group of trained and supported volunteers working from GP surgeries. It's about connecting people to non-medical sources of social, practical or emotional support as there is increasing evidence to support the use of **social interventions** for people experiencing a range of common health problems. People are referred into navigation by GP's and other practice professionals.

A snapshot of the navigation process



Community Navigators within GP practices enables integration within primary care; it makes positive use of the knowledge and skills that GPs have in order to know which of their patients would benefit from navigation and acts as a bridge between community activity and GPs. It is not trying to provide a service but navigating people to the right ongoing service and as such empowers clients, promoting self-awareness, choice and self-care.

Community Navigation can help ensure that GPs are able to make more appropriate use of their time and can reduce the levels of frequent attendance and the levels of prescribing for mild to moderate depression[10].

Further Reading

If you would like to find out more about any of the legislation or policy mentioned within this document there are a number of sources of information detailed below that could be helpful.

- The Care Act (Brighton and Hove City Council)
- Overview of the Care Act (Skills for Care)
- The Brighton and Hove Better Care Fund: Planning template – Part 1 (Brighton and Hove City Council)
- The Brighton and Hove Better Care Fund: Planning template – Part 2 (Brighton and Hove City Council)
- Making best use of the Better Care Fund: Spending to save? (The Kings Fund)
- Brighton and Hove Joint Health and Wellbeing Strategy (Brighton and Hove City Council)
- 'Aging Well' in Joint Strategic Needs Assessment (Brighton and Hove City Council and Brighton NHS)
- Integrated Care - The Better Care Fund (Local Government Association)
- Joined up care – Sam's story (The Kings Fund)
- Making integration a reality part 1: Joining up the commissioning of young people's services across health, social care, housing and youth services (Youth Access)
- My Life Brighton & Hove

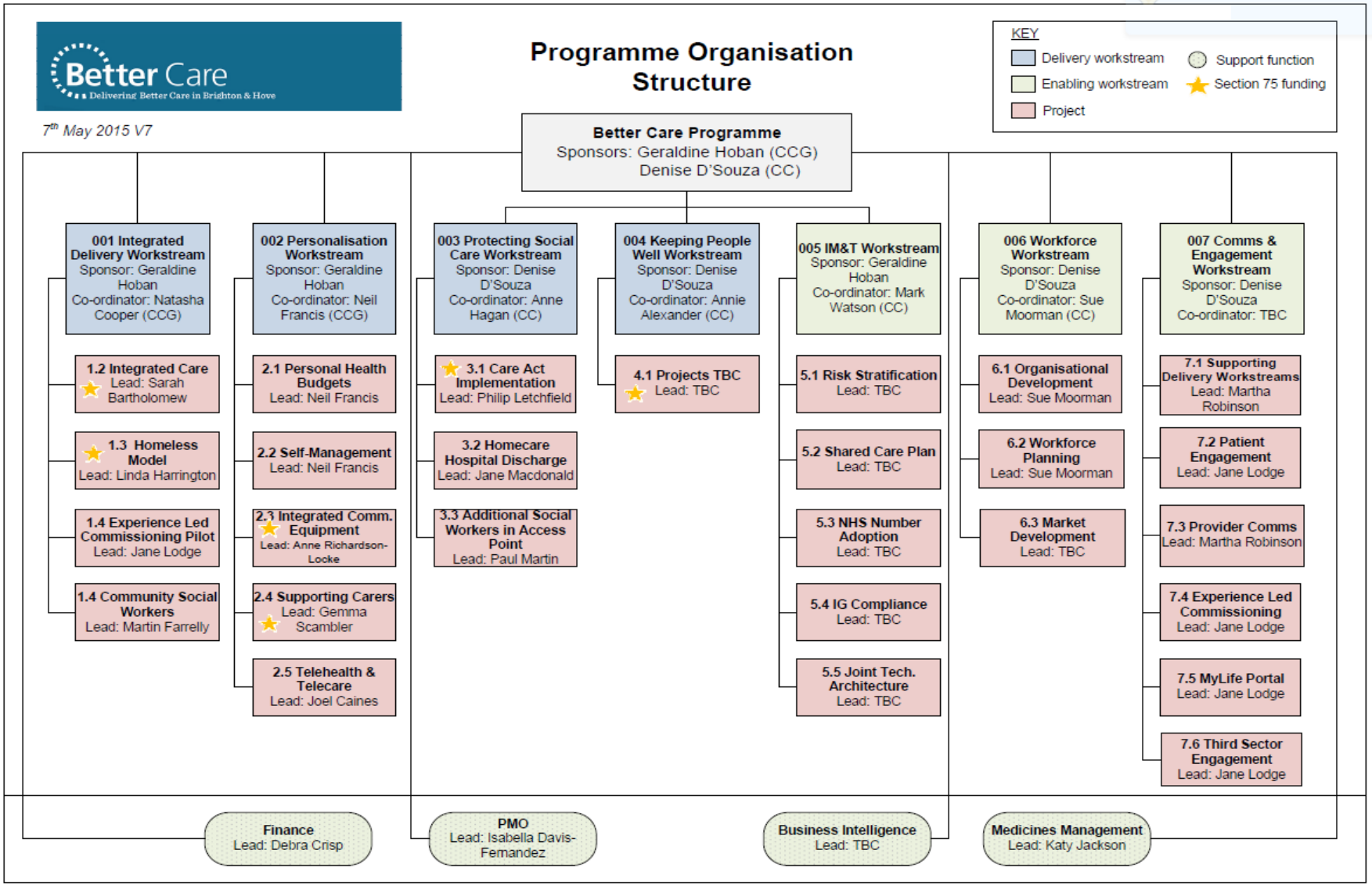
[10] http://www.cvsnewcastle.org.uk/assets/files/networkinginvolving/social_prescribing_report.pdf

Appendix One - Health and Social Care Glossary

Clinical Commissioning Group / CCG	CCG's are GP led NHS organisations set up by the Health and Social Care Act 2012 to commission local health services on behalf of the population they serve.
Brighton and Hove City Council / BHCC	BHCC is a unitary authority and is responsible for the provision of all local government services within Brighton and Hove. They are constituted under the Local Government Act 1992. They are in charge of local services such as housing, education, some benefits and council tax among other things.
Sussex Community Trust / SCT	SCT are the main provider of NHS community health services across Brighton & Hove. They provide a wide range of medical, nursing and therapeutic care. They work to help people plan, manage and adapt to changes in their health, to prevent avoidable admission to hospital and to minimise hospital stay.
Sussex Partnership Foundation Trust / SPFT	SPFT provide mental health services for people with conditions such as psychosis, depression, anxiety, dementia and personality disorder. They provide specialist learning disability services provide community and inpatient care for people with complex health needs. They provide care in people's homes, in specialist clinics, hospitals, GP surgeries and prisons.
Brighton Sussex University Hospital / BSUH	Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital working across two sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. They provide District General Hospital services to the local population in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England.
Brighton and Hove Integrated Care Service / BICS	BICS are a not-for-profit social enterprise and primary care federation, bringing together GPs, clinicians, staff and other health partners to improve services and patient care and deliver services. BICS have managed the EPiC programme (see below)
EPiC	Extended Primary Integrated Care- pilot programme with five work streams: GP Triage, Extended Hours and Skill Mix, Pharmacy, Community Navigation and Redirection of Workflow. Shares patient data with community nurses and pharmacies
Commissioning	Commissioning is the word used to describe the decision-making process that decides which services or activities are required in local areas, and which resources to allocate to them or to buying them.
Commissioner	A commissioner is the person(s) responsible for this decision-making process for a particular service or activity.
Community Navigator	Trained volunteers who help patients by onward referral to community activities and personal support (a work stream of EPiC pilot programme).
Proactive Care	Is a de-medicalised way of working with people which puts them at the centre of their care. In Brighton and Hove it is also the name of a service run by BICS which aims to identify people who are frail and vulnerable and improve the care they receive through Multi-Disciplinary Team (MDT) working (see below).
Risk Profiling	Risk profiling is a way of formally identifying those most vulnerable of becoming unwell. This is done by a risk stratification tool using specific formulations. Those identified are then referred on to MDTs.
Multi-	MDT's are communities of practice based professionals around GP practice

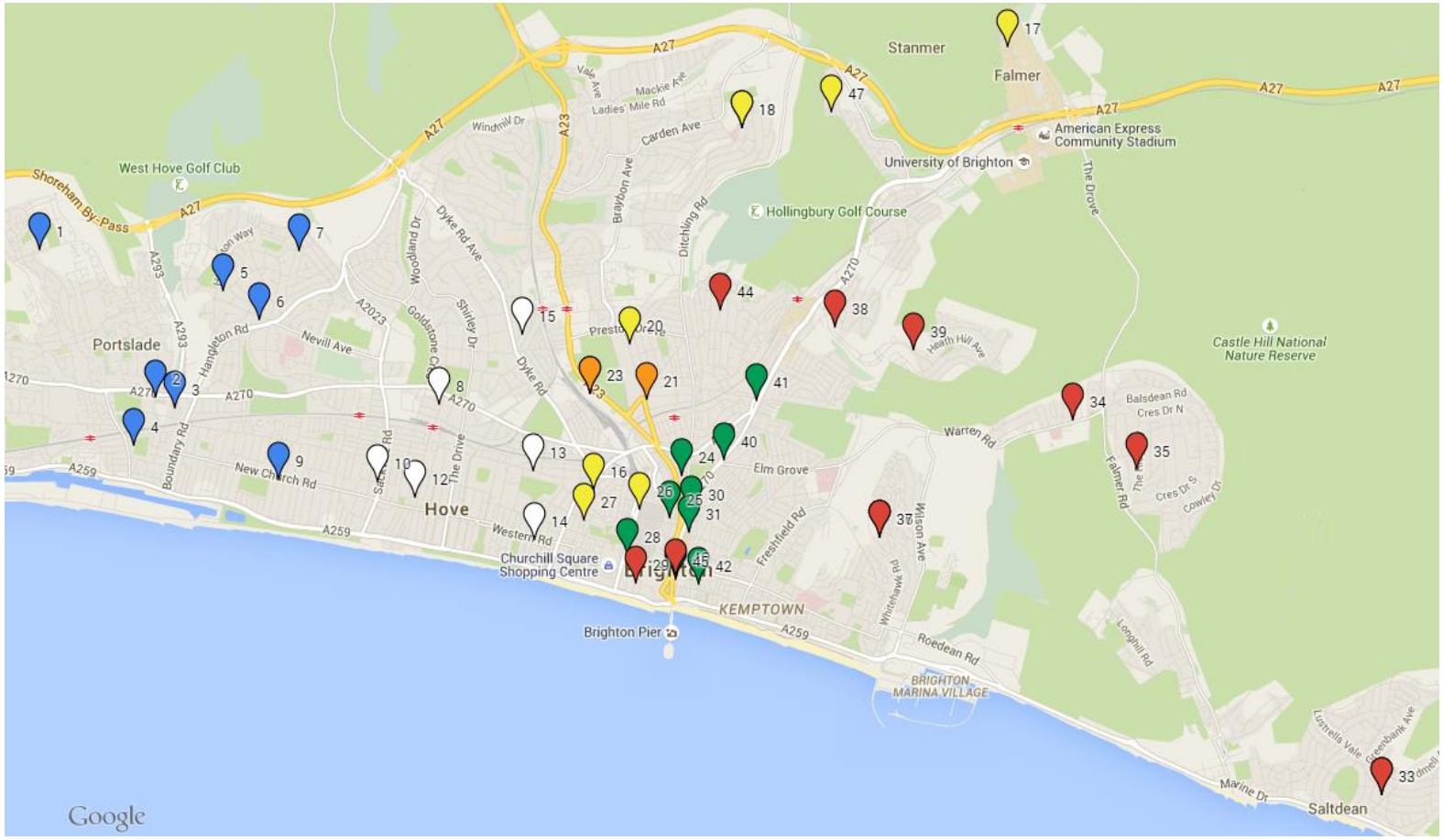
disciplinary Teams / MDTs	populations, with a focus on care for those most vulnerable. For example the teams are drawn from physical and mental health services, social care, third sector providers, GP practices and pharmacies and supported by independent sector provision.
Care Planning	This is what happens at an MDT where a group of professionals discuss the way a patient can achieve their goals and receive the care best suited to them.
Personal Health Budgets / PHB's	PHB's are an amount of money to support patients identified health and wellbeing needs. The aim is to give people with long-term conditions and disabilities greater choice and control over the healthcare and support they receive. Personal health budgets work in a similar way to the personal budgets that many people are already using to manage and pay for their social care
Integrated Working	This is a way of working where health and social care – along with partners from housing, education and the Voluntary and Community Sector – share decision making and service delivery to ensure the best outcomes. This way of working is mandated through The Care Act and Better Care.
GP Clusters	GP practices will now be working in 6 geographical clusters across the city. Whilst there will not be colocation of services much of the planning and prioritisation of care will be done in clusters.
Locally Commissioned Services / LCS	LSC's are a way of commissioning services which involves GP practices in assessing local needs, helping to identify local priorities and proposing new care pathways.
PPGs	Patient Participation Groups are the forums which allow patients to have their say around how their practice is run and arranged. Each surgery must now have one.
Wellbeing	Wellbeing a term defined within The Care Act and relates specifically to nine key areas ranging from personal dignity to a right to protection from abuse. It is the foundation from which the general responsibilities, duties and responsibilities of The Care Act arise.

Appendix 2 – Better Care Structure



Appendix 3

ProActive Care Brighton & Hove GP Practices



Cluster One (Green)	
30	Albion Street Surgery
42	Ardingly Court Surgery
28	Boots North St (The Practice PLC)
31	Brighton Homeless Healthcare Centre (The Practice PLC)
40	Lewes Road Surgery
25	North Laines Medical Centre
41	Park Crescent Health Centre
45	Pavilion Surgery
24	St Peters Medical Centre

Cluster Two (Red)	
38	Avenue Surgery
36	Broadway Surgery
46	Regency Surgery
35	Ridgeway Surgery
33	Saltdean & Rottingdean Medical Practice
44	School House Surgery
29	Ship Street Surgery
32	St Lukes Surgery
37	Whitehawk Medical Practice (The Practice PLC)
39	Willow House (The Practice PLC)
34	Woodingdean Surgery

Cluster Three (Orange)	
23	Beaconsfield Medical Practice
21	Preston Park Surgery
22	Stanford Medical Centre
19	Warmdene Surgery

Cluster Four (Blue)	
7	Benfield Valley Healthcare Hub
2	Benfield Valley Healthcare Hub - Portslade County Clinic
5	Hangelton Manor Surgery (The Practice PLC)
6	Hove Medical Centre
3	Links Road Surgery
1	Mile Oak Medical Centre
4	Portslade Health Centre
9	Wish Park Surgery

Cluster Five (Yellow)	
26	Brighton Station Health Centre
18	Carden Surgery
27	Montpelier Surgery
47	New Larchwood
16	Seven Dials Medical Centre
20	The Haven Practice
17	University of Sussex Health Centre

Cluster Six (White)	
14	Brighton and Hove wellbeing centre
12	Central Hove Surgery
13	Charter Medical Centre
8	Hove Park Villas Surgery
15	Matlock Road Surgery
10	Sackville Medical Centre