



East Sussex Better Together



Commissioning Intentions and Market Position Statement

2016/17

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Introduction

Improving the health and wellbeing of local people and enhancing the quality and experience of clients and patients is central to the way we plan and commission services.

Here in East Sussex, as in most health systems across the world, demand for NHS and social care services is increasing rapidly. Our population is growing and people are living longer. There is an increase in chronic conditions, with more and more of us requiring long-term support. As patients, we also expect to receive high quality and consistent care, resulting in the best possible outcomes for ourselves and others. However, the reality is that the money we have to pay for health and social care is likely to stay about the same, which means demand is growing faster than our budget.

Research and evidence tells us that safe and sustainable health and care services will only be delivered through fundamental, whole system service and commissioning transformation, including health and social care integration. In August 2014 we launched our ambitious, 150 week whole system transformation programme, East Sussex Better Together (ESBT) – a partnership between East Sussex County Council, Eastbourne, Hailsham & Seaford Clinical Commissioning Group and Hastings & Rother Clinical Commissioning Group – to make sure that we use our combined annual circa £850m budget to achieve the best possible outcomes for local people.

Since the programme launched we are proud to be transforming services for the better, and for the support we have from local stakeholders and partner organisations. Together, we are improving access, bringing together health and social care, improving emergency care, improving health and wellbeing, ensuring better use of medicines, ensuring better community services and tackling health inequalities.

Building on the Adult Social Care & Health (ASCH) and Children's Services Portfolio plans, and the Clinical Commissioning Groups (CCG) Operating Plan, for the first time this year we have produced this overarching and integrated document to describe the overall context of the health and social care economy in East Sussex, and the drivers behind the transformation that we need to make by 2018. Whilst the work streams driving the transformation are still developing, we have tried where possible to highlight some of the key messages and development opportunities for businesses, organisations and groups that help deliver health and wellbeing to our local population, and who want to work with us to achieve this change.

We know the health and social care market is under pressure in East Sussex. Whilst the local authority has worked hard to protect social care budgets from the overall reduction in funding from central government, increasingly the funding available to us needs to be prioritised for those with the most significant and urgent needs and difficult decisions will continue to be required. In recognition of this we are looking at other ways that we can support providers to enhance quality and address some of the fundamental issues in the market.

This document is intended to support discussion and debate in the coming year to ensure that together we are able to develop a sustainable service offer, and continue to deliver quality outcomes for our local population.

Keith Hinkley, Director of Adult Social Care and Health

Amanda Philpott, Chief Officer of EHS CCG and H&R CCG

Stuart Gallimore, Director of Children's Services



For ESBT programme and event updates please see: <https://news.eastsussex.gov.uk/east-sussex-better-together>



Part 1: Integrated Commissioning Statement

East Sussex Better Together – whole system transformation of health and social care in East Sussex

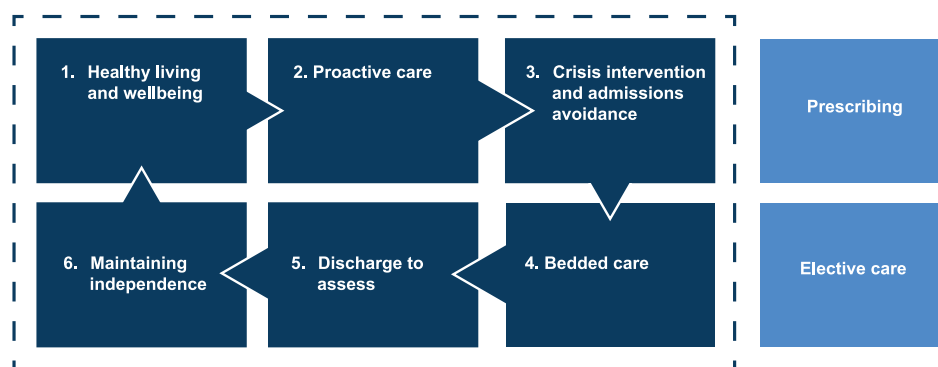
Background and vision

During 2016/17, health and social care commissioners across the whole of East Sussex will spend £1.06 billion on health and social care services. Our population is growing, people are living longer and there is an increase in chronic conditions with many more of us requiring long-term support. Demand for services is not only changing but growing – at a faster pace than our budget.

East Sussex County Council, Hastings & Rother CCG and Eastbourne, Hailsham and Seaford CCG are working together with local people and stakeholders to design and commission safe, high quality and more integrated health and social care services that will meet the needs of people now and in the future. Launched in August 2014, ESBT is our bold and transformative approach to developing a fully integrated and sustainable health and social care economy in East Sussex. We aim to achieve this through a 150 week whole system programme designed to invest to the best effect the combined circa £850 million we spend on health and social care services on behalf of our population.

Our shared vision is that by 2018 there will be a fully integrated health and social care economy in East Sussex that makes sure people will receive proactive, joined up care, supporting them to live as independently as possible and achieving the best possible outcomes.

To achieve this we have developed a framework known as the 6 plus 2 box model of care. The six boxes describe the services and support required throughout the whole cycle of an individual's care and support. Two further boxes are additional areas where we want to improve the quality and affordability of services.



Healthy living and wellbeing: preventing ill health for the whole population including helping all children get a good start in life, promoting independence and improving awareness of and access to services and support for both adults and children, that support healthy living, maintain wellbeing and make best use of community assets.

Proactive care: providing integrated and targeted health and social care services to support children and families in need, enabling children and adults with long-term conditions and illnesses to maintain health and independence for as long as possible, promoting self-care and self-management and to avoid having to go into hospital or complex accommodation-based care.

Crisis intervention and admissions avoidance: providing fast and responsive services to keep children safe and prevent family breakdown. Ensuring the right services are in the right place at the right time to help children and adults regain their independence and well-being quickly following a period of illness, and to avoid admission into hospital or complex accommodation-based care where unnecessary.

High Weald, Lewes and Havens

High Weald, Lewes and Havens CCG (HWLH) and East Sussex County Council are developing a programme entitled **Connecting 4 You** to coordinate the joint plans of the CCG and the Council with partners and stakeholders, including providers and resident population, to implement the NHS Five Year Forward View and to ensure high quality, sustainable services into the future that best meet the population needs of HWLH, now and for future generations.

Connecting 4 You is in its formative phase. The themes reflected in ESBT of healthy living and wellbeing, proactive care, crisis intervention and admissions avoidance, bedded care, discharge to assess and maintaining independence are likely to also be reflected in the Connecting 4 You programme, though they may be delivered differently at a local level.

Bedded care: making sure that people who require in-hospital and complex accommodation-based care receive the best possible services, and only for the amount of time it is required.

Discharge to assess: ensuring patients and clients in hospitals and care homes are discharged as quickly as possible to an appropriate place, with a package of care to support their recovery.

Maintaining independence: supporting users of health and social care services, and their carers, to live independent lives.

Prescribing: ensuring people receive effective and appropriate medicines when they need them, and reducing the amount of medication that is not taken as prescribed.

Elective care: streamlining planned care to ensure local people have choice, are able to make informed decisions about their care, and have the earliest appropriate intervention.

Ever increasing demand and the need for high standards of care mean that we face a potential funding gap of £135 million by 2020 if the status quo of the current organisation of services is maintained. Due to the size and urgency of the challenges faced by the health and social care system in East Sussex, the next year of our programme therefore needs to focus on delivery to ensure that resources are directed where they are of best use and to guarantee sustainability. Within this we will need to consider new approaches to arranging health and social care services, if we are to secure the future of our NHS and social care for the next generation in East Sussex.

Introducing New Models of Care – ‘Accountable Care’

By 30th June 2016 we will be 100 weeks into our 150-week whole system programme to transform and fully integrate health and social care services, making them sustainable for future generations in East Sussex. On the basis of our research over the last year the Programme partners believe Accountable Care is likely to be the most effective vehicle to deliver that vision, building on the strong progress already made, offering us the best and possibly only opportunity to resolve provider sustainability across local DGH, community, primary, mental health and social care services in East Sussex. After initial discussion and engagement, the ESBT Programme Board has agreed to develop a full detailed business case for implementing an Accountable Care model in East Sussex, which will be presented through governance processes in November.

Nationally, building on the Better Care Fund, the NHS Five Year Forward View provides commissioning and provider organisations with new flexibility needed to design new models of ‘accountable care’ achieve the ‘triple aims’ of health and social care systems:

- improving the health outcomes of populations,
- enhancing the quality and experience of people’s care, and
- reducing the per-capita cost of care.

Accountable care focusses on delivering local health and social care services based on the outcomes, or results, for patients and service users. Put simply, it means the health and care system is geared towards preventing ill health (keeping people well) and promoting independence and wellbeing, while ensuring we have high quality hospital, care and specialist services when people need them. This approach is already being used successfully in other countries around the world. Although there is no one single model of Accountable Care, there are four things that are usually present in this kind of system:

- One budget for all of the health and social care needs of the local population.

Better Care Fund

The Better Care Fund (BCF) was announced in June 2013 as part of the 2013 Spending Round, and as such is nationally mandated. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The BCF is an important enabler to take the integration agenda forward, acting as a significant catalyst for change.

Accountable Care

Accountable Care models move away from activity based contracts and payment for episodes of treatment and elements of care to positively incentivising the system through outcomes based contracting and a capitated budget payment mechanism. The model entails a provider (or group of providers) being held jointly accountable for achieving a set of outcomes for a defined population over a period of time and for an agreed cost under a contractual arrangement with a commissioner.

- Longer contracts for health care providers so that they can make long-term decisions on things that work.
- Joined up IT systems as the models rely on closer working between different providers.
- A culture of accountability and collaboration across health and social care organisations.

You'll be hearing more about how this model could look in East Sussex, and we are aiming to agree the detailed business case in November 2016, working with our key partners to inform development. In the meantime, you can find out more with a short video: [East Sussex Better Together](#). Further information can also be found at www.eastsussex.gov.uk/accountablecare

Demographic information for East Sussex

East Sussex has a population of 539,800 residents (mid-2014 estimates). This has increased by 7% over the last ten years. In East Sussex migration is the key driver behind population growth with the number of deaths exceeding the number of births. The total population is projected to increase by 4% over the next ten years to 561,700 by 2024.¹

East Sussex has had an older age profile compared to England & Wales and the South East for at least the last 30 years. 61% of residents are aged between 18 and 64, and 23% aged 65 years or older (134,000), of these around 21,000 people are aged 85 years old or over. In ten years' time it is estimated the population aged over 65 will increase to around 160,000.¹

While the health of people in East Sussex is generally better than the England average, there are significant variations in health outcomes across the county. For example, there is significant variation in life expectancy with a 7.3 year gap between the areas with the highest and lowest life expectancy for men and a 6.7 year gap for women.² Rates of some conditions also vary with more deprived areas having significantly higher rates of some conditions such as cancer and cardiovascular disease compared with areas with lower levels of deprivation. Older people, and those living with Long Term Conditions (LTCs) account for a disproportionately high level of all health and social care activity and spend, and the number of people with co-morbidities is expected to continue to increase. In 2011, 20% of people in the county had a long-term health problem or disability and by 2024 this is projected to increase to around 22% of the total population¹. People with LTCs account for 50% of all GP appointments, 64% of outpatient appointments, 70% of all inpatient bed days and consume 70% of the total health and care spend³.

Whilst the numbers of eligible working age adults with learning disabilities will remain relatively static, people with complex health and social care and support needs are living longer and the number of older people with learning disabilities will increase. It is a key priority to support young people coming through transition to access high quality, value for money services to enable them to maximise their choice and control and live their lives as active members of their community - this will inevitably result in a shift of resources from people with mild/moderate needs to those with profound and complex needs.

Nationally, mental health problems make up 23% of the total 'burden of disease' compared to 16% for cancer and 16% for heart disease.

Tackling Health Inequality

Health inequalities are differences between people or groups due to social, geographical, biological or other factors, they result in people who are worst off experiencing poorer health and shorter lives. In East Sussex we are using our combined efforts to address these unacceptable differences by addressing health inequality in everything we do so that we improve the health of those with the poorest outcomes fastest. In addition we are also targeting resources on specific geographical areas or groups who are known to have poorer outcomes. www.hastingsandrotherccg.nhs.uk/about-us/plans-and-strategies/healthyhastingsandrother

¹ East Sussex in Figures. Accessed 18 May 2016 at www.eastsussexinfofigures.org.uk

² Public Health Outcomes Framework Indicator 0.2iii at www.phoutcomes.info

³ Long Term Conditions Compendium of Information: Third Edition (2012) Department of Health

Recent studies show that people with long-term conditions are two to three times more likely to experience mental health problems than the general population⁴. Around 20% of the adult population (over 60,000 people) in East Sussex will experience a common mental health problem such as depression or anxiety in their life-time. Of those people with mental health needs around 3% of the population (over 7,000) may need substantial support to manage their mental health condition.

Carers make up 11% of East Sussex's population. The East Sussex Carers Strategy⁵ identifies there are approximately 59,000 carers who spend a significant proportion of their time providing unpaid support to family or friends. The majority of carers in East Sussex are of working age with 26% being aged over 65.

Carers have identified that caring can have a negative effect on their physical and mental health. Research has confirmed that carers suffer more stress, poorer health and generally have a lower income than those who are without caring responsibilities.

Children

Children aged 0-4 years make up 5.2% of the population, with this proportion predicted to steadily decrease over the next 10 years, with the largest decreases predicted in Eastbourne and Hastings.

A lower proportion of children and young people are from ethnic minorities, compared with the England average with only around 10% of 0-14 year olds non-white British, compared with 25% in England as a whole. The majority of children aged 0-19 (74%) live in urban locations, with around one quarter (26%) living in rural areas (in towns/on the fringe of towns, in villages and dispersed). Children are more likely to live in overcrowded households in some areas of the county than others, with 7% of households on average overcrowded across East Sussex. Rates of overcrowding are highest in Eastbourne (10%) and Hastings (9%) and lowest in Wealden (4%).

17% of the children aged under 16 in East Sussex are living in poverty with the highest percentage in Hastings where over a quarter (28%) of children affected by income deprivation. Wealden has the lowest levels of income deprivation where 1 in 10 (10%) are affected.

Rates of children achieving a good level of development in the Early Years Foundation Stage vary across the county with on average 66% of children achieving a good level, with the highest rates observed in Wealden (72%) and the lowest in Hastings (62%).

Financial context

Collectively we are facing a real challenge across the health and social care economy. Over the next four years there will be much less money for local government services in East Sussex, even though demand for them is rising. This is largely because funding from central Government is shrinking. East Sussex County Council needs to make savings of between £70 million and £90 million by March 2019. This is on top of £78 million we have already saved since 2010. We will still invest around £350 million a year in services for East Sussex, but even this means making a saving of at least 20%. It will affect all of us – because it's the equivalent of £300 a year less to spend for each man, woman and child in East Sussex than at the start of the decade (that's £600 a year less per household).



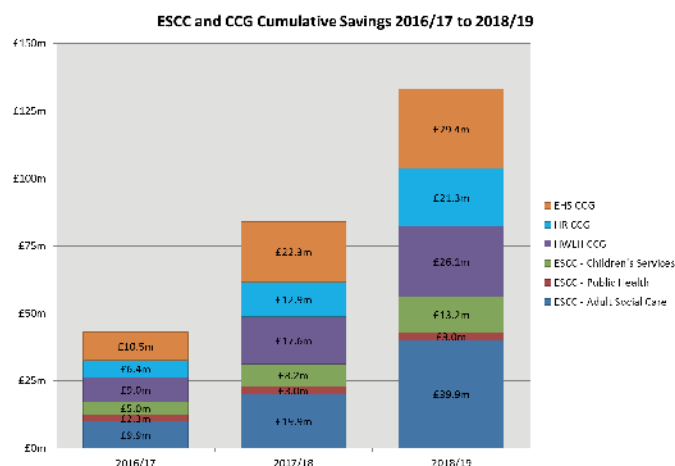
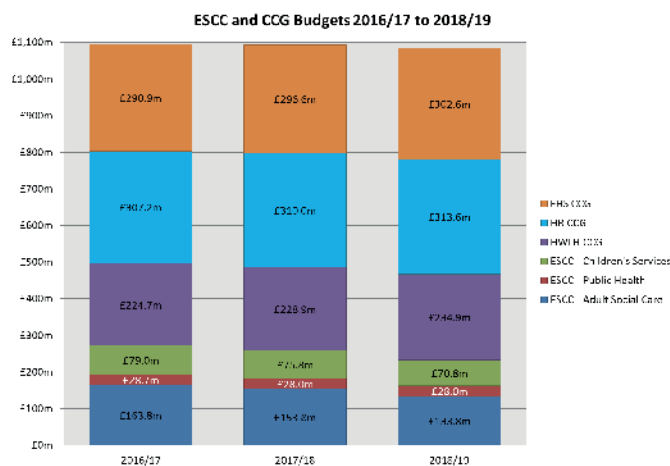
⁴ Long-term conditions and mental health – The cost of co-morbidities, The Kings Fund

⁵ East Sussex Joint Commissioning Strategy for Carers' Services Refresh 2013-2015

Most of our services will change and some will cease. In Adult Social Care we need to save £40 million over the next three years, whilst having to manage the increasing demand for services from a growing adult population (increasing by 1% over the next 3 years to 453,300 by 2018; with over 85 years of age growing by 3.5% to 12,900), plus increasing complexity of need; such that pressures in excess of £5m p.a. have been identified in the Medium Term Financial Plan. Savings proposals for the next 3 years will also impact on Children's Services (£13.1m by 2018/19). The announcement of the Council Tax Levy of up to 2% per annum from 2016/17 to 2018/19 has enabled the Council to raise £4.657m in 2016/17 which has been used to mitigate a number of proposed savings and meet service pressures within Adult Social Care. However, significant pressures continue to arise, for example, as a consequence of the introduction of the National Living Wage; plus changes in the funding regime for Local Authorities will add complexity to the financial position transitioning from revenue support grant to business rate retention.

East Sussex has received confirmation of its Public Health grant funding for 2016/17 (£28.697m) and indicative funding for 2017/18 (£27.99m). Whilst this is an improved position on our initial planning, which assumed a funding reduction of £4.8m in 2016/17, the reduction in grant is confirmed at £2.339m in 16/17 and an indicative further reduction of £707,000 in 17/18 which represents savings of 13% across the two years. Whilst the budget for future years is not known a reduction in grant of on average 3.9% per year to 2020 has been indicated.

Total available resources (see bar chart below) across Adult Social Care, Public Health and Children's Services will reduce from £271.5m in 2016/17 to £232.6m by 2018/19, a reduction of 14.3%. For the three CCGs, allocation of funding between 2016/17 and 2018/19 shows an increase of £28.3m. We need to look collectively at the impact this will have on the whole system and work collaboratively across organisations to use the collective resource more efficiently and where it has the most positive impact on people's lives.



Year of Care Costs

A fundamental founding principle of the ESBT programme was to focus on spending the entirety of our collective health and social care budget well, looking at the entire year of care costs to shift from 'what do we need to save' to 'how do we spend £850million more wisely'. Our financial modelling indicates that Year of Care costs increases from £2,189 pp to £2,868 pp if we do not change the current organisation of services and reduces to £2,340 when we move to a more integrated model of care.

Investing in the whole system

The vision for East Sussex Better Together is to have an integrated health and social care economy by 2018, moving towards an accountable care model by 2017/18. The 6+2 box pathway allows us to look at investment across the whole health and social care economy and maximise the effectiveness of the resource we have available at a local level. At present 75% of the resource we have is invested in bedded care; acute beds, residential and nursing care. We need to move investment out of these settings to ensure that, where appropriate, people are able to receive the services they need in the community. There are a number of key steps that we need to take to move towards an accountable care model and a more integrated economy and decision making process with the resources we have available to us. By June 2016 we will have agreed the joint investment planning process across ESBT to inform the start of the budget-setting cycle for 2017/18. We are designing and developing a single planning and commissioning process that will be supported by the joint investment plan, and which will enable collective decision-making about the shared approx £850m resource envelope for 2016/17 (recognising the funding gap arising from pressures in the system of £50m) and be aligned to the 6+2 box model.

We will also be designing the locality planning and commissioning arrangements to support the Integrated Locality Teams (ILTs). Part of this will include considering the options for the way the Voluntary and Community Sector (VCS) is funded as providers of care, support and wellbeing in community settings, building on the Commissioning Grants Prospectus process we have used for the last four years.

Quality

The provision of good quality health and social care is a key outcome for children and adults with care and support needs. The services commissioned by Health need to be high quality, safe and effective. There is a well-established program of assurance which includes regular quality visits to providers, as part of contract, performance and quality monitoring. Listening and engaging with the population about their experiences of the quality of services provided is crucial. This is achieved through a variety of ways and working closely with Healthwatch and other stakeholder groups. We will work increasing closely across health and social care to make sure all our services are of the very best quality and will work with providers to drive service improvement to meet the needs of our populations.

When care home placements are suspended as a result of warning notices, the number of beds available reduces. This increases pressure across the whole health and social care system and impacts on our ability to facilitate timely discharge from hospital. There is particular concern around nursing and dementia care beds, where demand continues to increase. In response to this, ASCH has established a cross-functional team to respond immediately to the growing number of suspensions and provider failures in the care home market. To ease the pressure on dementia and nursing beds, existing staff with appropriate skills will work together to diagnose the problems and directly support appropriate providers. The team will work in partnership with the Registered Care Association (RCA) and the approach supports existing business continuity arrangements. At the time of writing, the team is being established and starting to embed the new way of working. Over time, the aim is to work in a pro-active way with establishments to avoid suspension and warning notices before they occur.

Further, we are currently refining our understanding and application more broadly of care governance in light of the financial challenges faced and to support ESBT programme development. We have recently consulted with a wide range of providers, stakeholders and commissioners to understand, with the limited resources available to us, how best we can assure ourselves of

Market sustainability

For adults, sustainability of the care home market is an ongoing concern in East Sussex and at the time of writing 13-14% of care homes in the South (Surrey, Kent and East Sussex) are rated as inadequate or with warning notices from the Care Quality Commission.



Support with
Confidence
EAST SUSSEX COUNTY COUNCIL

Support with Confidence

East Sussex ASCH and Trading Standards have established a quality accreditation mark for community based providers of care and support – the Support With Confidence scheme. With over 150 members, the scheme is growing and gaining wide recognition amongst the local community.

For providers the scheme offers training, ongoing business support and many opportunities to network with other local providers, and is a way of assuring and displaying quality to the wider market, including people buying their own care and support services.

the quality of provision whilst also providing the right advice and support to the market – whose sustainability is critical.

From the broad range of feedback and information gathered we have concluded that the current approach to quality monitoring has not been working. Through the review we have identified four key priority areas that we will focus on in the future. These are:

- Supplier and market intelligence
- Quality assurance and improvement
- Business development and support
- Safeguarding

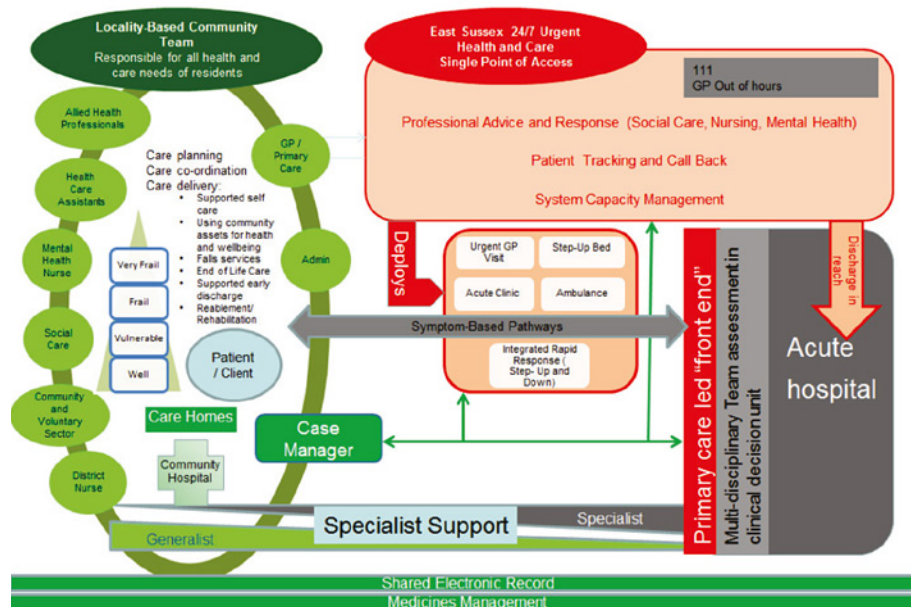
We are now considering a number of options regarding different approaches to working with the market to ensure its long-term sustainability, and are developing our plans in more detail along with the timetable for moving towards the new approach. We will keep providers informed through the regular RCA meetings, provider forums and newsletters.

Achieving transformation

By 2018 there will be a fully integrated health and social care economy in East Sussex that makes sure people will receive proactive, joined up care, supporting them to live as independently as possible and achieving the best possible outcomes. Our system relies too much on people having to travel to hospitals to receive services that could be provided more easily at home or in the community. So we're investing in improving the range, quality and consistency of services available in the community, in GP practices and outside of hospitals.

The needs of people with long term conditions transcend the traditional organisational boundaries for primary, community, social and secondary care. Research on hospital flow and point prevalence studies show that between 10 to 20% of people did not need to be admitted and up to 30% would not need to remain in a hospital bed if adequate alternative models of service provision were in place.

Furthermore the current system of health and social care provision is predominately based on a reactive model of care, with clients receiving intervention from professionals working in relative isolation on a condition or presenting need basis, with some duplication of effort. There are significant opportunities to work towards a holistic, more proactive model of care, utilising an inter-disciplinary approach, shared assessments and a self management approach when appropriate. The diagram below shows our vision of how this integrated system will look by 2018 for adult health and social care:



Children & Families:

We will be thinking further about how this model works for children and families over the coming year.

In order to achieve this radical transformation we have a widespread programme of work underway. Our current priorities are as follows:

Improving health and wellbeing

We're doing more to prevent illness, promote healthy living and support and enable individuals to take more control and responsibility for their health and wellbeing. We're developing ambitious plans to transform the way in which settings such as schools and nurseries promote health, with a particular focus on addressing childhood obesity. We're supporting workplaces and health and care providers to use every opportunity to improve health. We will use exciting new technologies to support people to be more active and manage their own health conditions.

We're organising our work to help people to stay well into four strands:

Environment:

The places where we spend our lives have a huge impact on our ability to stay healthy. In 16/17 we're working with schools, colleges and early years settings to support them to develop whole school health improvement plans. This will include schools developing or working with providers to embed health improvement opportunities in their everyday activity. We're also working with colleagues to develop support for employers to make workplaces healthier.

Communications and behaviour change:

We'll be reviewing our communications plans to make sure that we're making the most of the opportunities to help people to understand the impact that their behaviour has on their health and the things that they can do to change this. As part of this we'll be considering our commissioning intentions around social marketing, communications and campaigns.

Services and support:

A range of services to support people to change their lifestyles are currently commissioned. In 16/17 we'll be reviewing our service models and identifying the range of options available including the potential for integrated lifestyle services.

Workforce:

We're supporting healthcare providers to consider how they can Make Every Contact Count by skilling staff up to have brief health chats with patients about the things that they can do to improve their own health.

By 2018 our vision is that all people should be enabled and supported in achieving their full health and wellbeing opportunities potential through embedding prevention across the health and social care system at every level of need.

Our priorities for 2016/17 to enable us to work towards this vision are:

- Development of a prevention pathway
- Embed behaviour change across the whole pathway
- Ensure that delivery models for lifestyle services meet the needs of local people
- Ensure that staff have the knowledge and skills to support people to look after their own health
- Cross system actions that address childhood obesity
- Undertake a phased approach to commissioning Telehealth/Telecare (assistive technology)
- Engaging with people with Long Term Conditions, through a survey and focus groups, to help develop a future self-management model

Prevention:

Preventing people from developing health and social care needs, and slowing or halting the progression of people with an existing health or care need are key priorities.

We expect all providers to actively embed prevention into their core activity. This includes ensuring that staff have the necessary skills and ability to raise behaviour that impacts on health and care outcomes with clients, and proactively refer into services.

All providers will be expected to ensure that their services actively promote self-care and self management approaches to maximise outcomes for clients, and make the best use of available resources. This includes supporting clients and service users to access community support where appropriate.

Supporting community resilience

We need to work more closely with communities, and recognise their contribution to improving health and wellbeing. Community resilience is generated by community members coming together to identify and use community resources and strengths, for example voluntary groups, local businesses, parks, buildings, etc to help influence change in their community. This can enable people to remedy the impact of a problem, gain more control over their lives and circumstances, help people to lead healthier lives, take more control over their wellbeing and manage their health and care support needs.

The Care Act and the NHS Five Year Forward View identify the need for creating new partnerships with communities, creating new opportunities for health-related volunteering, and designing easier ways for voluntary organisations to work alongside the NHS. The Forward View recognises the expertise of patients and their families in managing long-term conditions and identifies the need to 'build on the energy and compassion that exists in communities'.

We envisage a greater place-shaping role for CCGs and Local Authorities with responsibility for health and social care, alongside new ways of working that ensure front line staff work proactively with the strengths and assets of local people such as family, friends and local informal and formal support networks.

A process of engagement, using asset based techniques, across the 8 East Sussex localities has identified four priority areas for building community resilience:

- Creating active communities/enhancing volunteering opportunities
- Collaborating across and within sectors and with communities
- Communicating
- Resourcing – including identifying the importance of very small amounts or resource

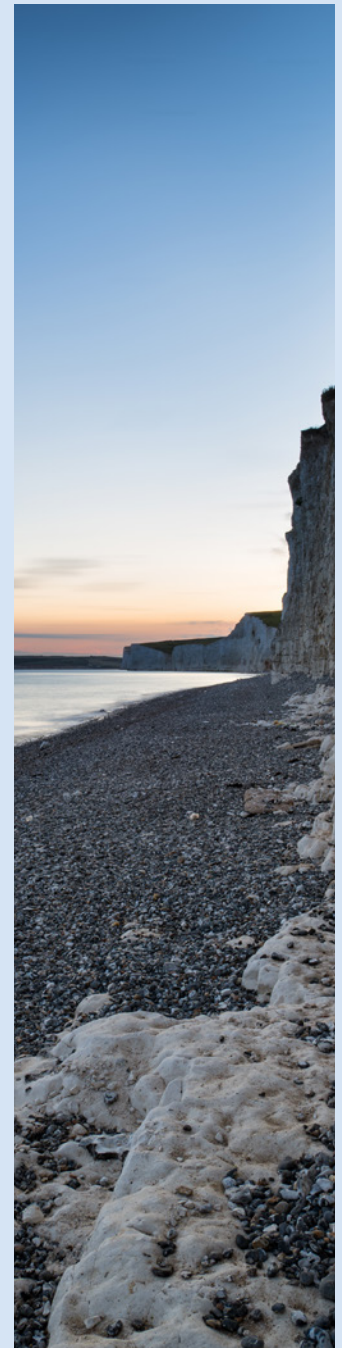
Harnessing our joint efforts to achieve the shared goal of creating more resilient communities is essential in a climate of reducing resources and rising demand. By recognising the strengths or assets that everyone has we can design a system which enables people to make the best of their own strengths, support others in their community to achieve their maximum potential, and working with communities to ensure we have the right combination of formal and informal support.

By 2018 we are working towards:

- A coherent and co-ordinated system which maintains and improves health and wellbeing and links people with a care and support need, or who are at an increased risk of health inequalities, to community interventions and support

In order to do this, in 2016/17 we are working with communities and local partners to:

- Ensure that our programme of community engagement underpins priorities
- Employ 8 Locality Link Workers to bridge the gap between integrated locality teams and communities
- Review how we support and enable people to become involved in their communities, including identifying new approaches to volunteering which meet local peoples aspirations
- Identify ways in which small amounts of resource can be made available to community groups delivering our shared ambitions

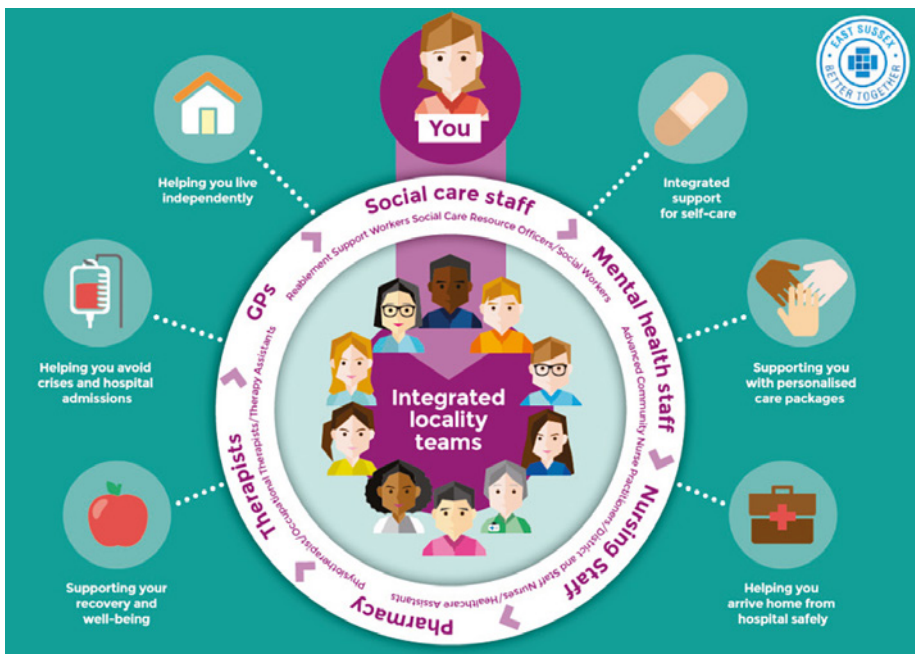


Bringing together health and social care

Where people do need more formal support from statutory services, an increasing number need care and support from both health and social care and these services have not always been co-ordinated as well as they should be. We're developing new community teams made up of health and social care professionals to support those with long-term needs.

For the first time, the health and social care needs of local people will be provided together by integrated teams. The team will provide personalised packages of care, supporting people to live independently and avoid being admitted to hospital where possible. When people are really ill and need hospital care, or need an operation, the team will ensure people are discharged with packages of care to support their recovery.

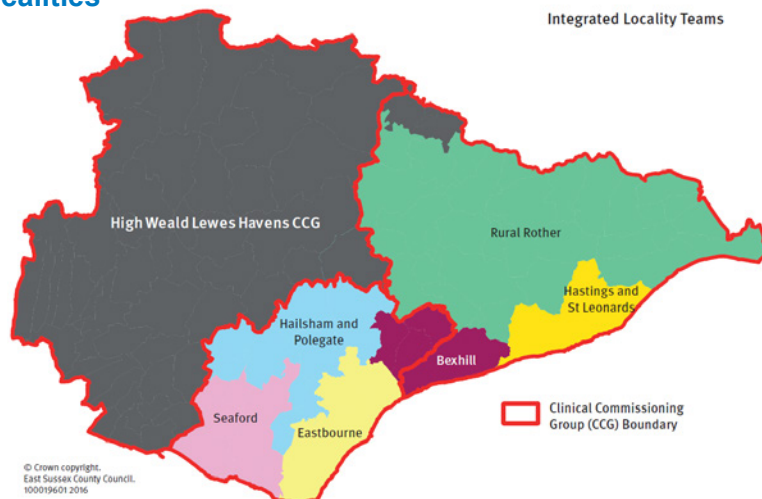
By 2018 we will have fully integrated adult locality teams, made up of nursing, therapy and social care staff delivering a full range of functions for that locality. The Teams will have access to Community Geriatricians and Proactive Care Practitioners to ensure that the right specialist support is available to support older people to continue living independently in the community.



Our key priorities for 2016/17 are:

- Create 6 Integrated Locality Teams (ILTs) in the Eastbourne, Hailsham & Seaford and Hastings & Rother localities, working across health and social care with single line management to provide locality based care rather than care based on existing organisational boundaries
- Create 8 locality Integrated Service Teams across East Sussex providing seamless services for families with children aged 0-5
- Create 2 CCG-wide crisis response teams in Eastbourne, Hailsham & Seaford and Hastings & Rother localities to provide rapid response to patients in crisis and prevent unnecessary hospital admissions
- Align Key Performance Indicators (KPIs) and create system-wide performance indicators
- Provide proactive care using risk stratification to identify people at risk and care plan accordingly – work to share these care plans across organisations at point of presentation

Map of localities



Improving access to services

We are also improving the way people with health and social care needs, families and carers can access local services. Health and Social Care Connect now provides a countywide hub for the public and health and social care professionals to access adult community health and social care services by phone, email or online. As a central hub, it provides a centralised, dedicated point for handling enquiries, referrals and coordinating responses, assessments and provision of services for adults who appear to be in need of community health and/or social care services.

Improved service coordination places local people and their carers at the centre of service delivery to ensure they have access to the information, advice and services they need, at the earliest opportunity, delivering improved health and care outcomes.

Health and Social Care Connect has been delivered in phases and became fully operational on 4 April 2016:

- In April 2015 an enhanced service for GPs was launched, offering GPs a dedicated line to a team of trained staff able to manage health referrals and any other enquiry, such as a social care assessment
- In September 2015 integrated management and frontline staffing began to be implemented and the services available expanded into evenings and weekends on a phased basis
- By 4 April 2016 the service became fully operational providing the full service offer 8am-10pm seven days a week including Bank Holidays via an integrated multi-disciplinary team comprising qualified social workers, occupational therapists and nurses and trained access and assessment officers able to deal with enquiries from the public and professionals

This enables us to deliver the following transformation:

- A centralised contact centre for adults in need of community health and/or social care services and the professionals who support them
- Quicker and easier access to information, advice, assessments, packages of care and services, including out of hours and at weekends
- Specialist advice from qualified staff including district nurses, social workers and occupational therapists
- Enhanced coordination of care for people with complex needs and/or requiring multiple services
- Enhanced co-operation and more consistent delivery of care, assessment and support across primary, community and secondary care and out of hours services

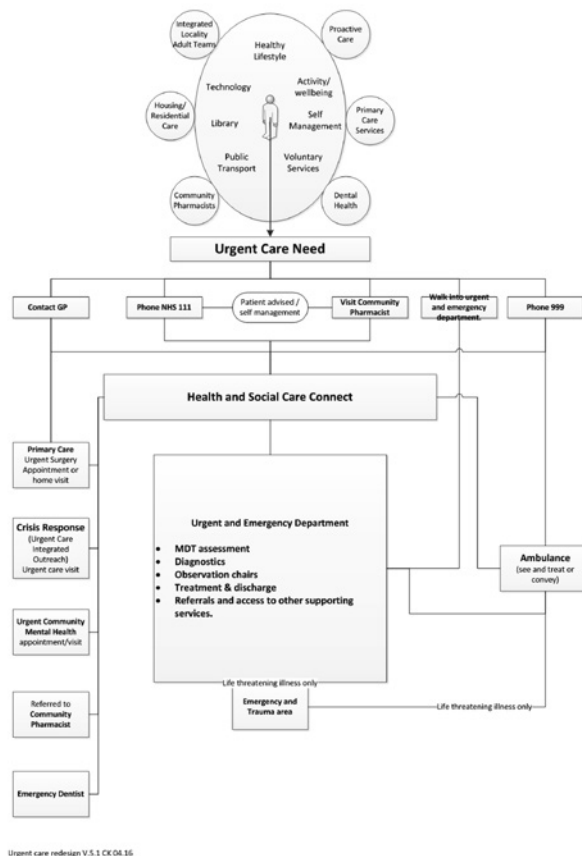
Access to Children's social care and Early Help services

From April 2016 there will be single front door for referrals for Children's social care and non-statutory early help, linked to Child and Adolescent Mental Health Services (CAMHS), so that referrals to CAMHS can be redirected, where possible without referrers needing to re-refer.

The new referral arrangements bring together digital information, advice and guidance which can be used by services to support families where levels of need are not sufficiently high to warrant targeted one to one support. GP practices will have named local contacts for health visiting and school nursing.

Improving emergency care

We all know there are huge pressures on A&E and other urgent and emergency care services. Often A&E is not the most appropriate place to go when you are unwell, but we know that local people sometimes use A&E because they don't know where else to go. We're developing new models for GP-led urgent care which will help people access appropriate treatment at the right time, as the diagram below shows:



By 2018 we are aiming to deliver:

- 7 day access across the urgent care system in East Sussex
- Outcomes and payment mechanisms for the local urgent and emergency care system

In 2016/17 our key areas of work will focus on:

- Assessment and the start of interventions in the community 7 days a week – to include, but not restricted to:
 - Home care assessment
 - Care home assessments
 - Crisis response
 - Community paediatrics
 - Community beds
- Developing and integrating urgent care pathways and services at the front of hospital 24/7 for all age groups
- Working with partners to inform development of a sustainable 24/7 medical support model for urgent primary care access
- Embedding 24/7 mental health liaison into emergency departments
- Review of the functions within the local NHS 111 system to ensure access and referrals onto local services where appropriate, and the provision of self-help advice

Better use of medicines

Research shows half of all medicines are used for the best therapeutic effect and/or are unused. That amounts to £45million wasted in East Sussex every year – money that should be improving the health of local people. A new emphasis is required to deliver Medicines Optimisation which aims to engage with patients to better understand their issues around medicines and to co-develop solutions that support them with their medicines taking. There will be specific focus around medicines use in care homes and in the over 75s because of our particular demographics and the known adverse impact of high medicine usage in the frail elderly population (polypharmacy).

The ESBT programme affords us the opportunity to work much more collaboratively across health and social care boundaries to ensure that there is adequate support throughout the medicines pathway to secure the desired outcomes for patients as well as delivering value for money for our CCGs. We will aim to increase capacity by integrating pharmacists' skills into co-ordinated primary care for patients and configure new medicines optimisation services around the locality model outlined in the CCGs Primary Care Strategy 2014-19.

By 2018 across EHS and HR CCGs we are aiming to deliver £2.6 million in savings through ensuring:

- 100% of practices are transmitting prescriptions electronically
- 100% of practices using patient specific decision aids that are integrated into the GP software systems
- 100% of nursing home residents that have a documented medication review that addresses polypharmacy and involves the patient and/or their relatives
- 100% of GP practices participating in the prescribing support scheme
- 2 WTE (whole time equivalent) clinical pharmacists carrying out medication reviews at practice/locality level

Streamlining planned care

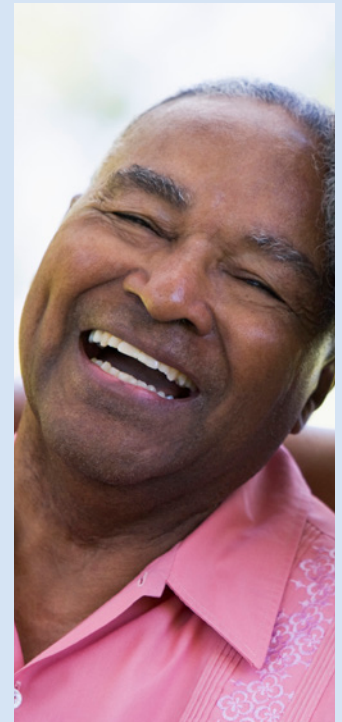
We are also seeking to ensure that when a person needs elective surgery, they receive that treatment and care in the most appropriate setting.

NHS RightCare and local referral data has shown us that demand for elective activity varies widely between GP practices. We need to streamline planned care to ensure that local people have choice and are able to make informed decisions about their care. Identified key speciality areas to focus on are:

- Cardiology
- Gastroenterology
- Diabetes
- Ophthalmology

To help us achieve this, in 2016/17 we are seeking to prioritise the following:

- Identification of inpatient procedures that can be provided as a daycase
- Identification of daycases that can be provided as an outpatient
- Reduction in first to follow-ups and in Did Not Attend's (DNAs)
- Reduction in consultant to consultant referrals
- Increased education for GPs and other referrers
- Increased/improved education and information for patients
- Earlier intervention and management so that people can be supported in out of hospital settings, closer to home
- Improvements in integrated working between all providers



Stakeholder engagement and co-design

We can only achieve our vision and effect the required changes in partnership with providers and the communities we serve. We will ensure that we update and involve all partners in ongoing discussions as progress is made in relation to the above work streams through provider forums, community events, reference groups, newsletters and focus groups.

The principle of co-design is central to informing our work to transform services as part of East Sussex Better Together. The co-design approach is based on the principle that the views and experiences of a range of people are vital to designing effective services.

We have established a Public Reference Forum that is run by Healthwatch to help us gather people's views to inform our work; to get involved you can visit: www.healthwatcheastsussex.co.uk/our-work/east-sussex-better-together

We also have a programme of events and opportunities for engagement. You can get up-to-date information at <https://news.eastsussex.gov.uk/east-sussex-better-together/events>



Part 2 Market Position Statement

The first part of this document describes the overall context of the health and social care economy in East Sussex, and the drivers behind the transformation that we need to make by 2018. This section looks at some of the key messages and development opportunities for businesses, organisations and groups that help deliver health and wellbeing to our local population, and who want to work with us to achieve this change.

We know the health and social care market is under pressure in East Sussex. Whilst the local authority has worked hard to protect social care budgets from the overall reduction in funding from central government, increasingly the funding available to us needs to be prioritised for those with the most significant and urgent needs and difficult decisions will continue to be required.

National policy is encouraging a more regional approach to services where economies and greater innovation can be achieved. For example, the Regionalisation of Adoption encourages providers and authorities to come together creating larger agencies to support adoption.

In adults' services too, providers have had to become more efficient, and they have had to do this at a time when the number of older people is growing faster than ever and people's needs are more complex. Many sectors of the market are under significant strain due to recruitment and retention issues. We know this is not easy, and want to work collaboratively with providers to ensure the long-term sustainability of the market and to deliver the best possible outcomes for our local population.

We are currently exploring a number of different ways that we can utilise our collective resource to deliver sustainable and good quality care and support for our local residents. For example, we have recently agreed to put additional resource towards delivering joint recruitment strategies to encourage more people to develop a career in health and social care, and are looking at what business support we can provide to care and support providers to develop key identified services where we currently have gaps in provision.

It is only through collaborative working that we can deal with the current challenges facing the health and social care economy, ensure a sustainable service offer, and continue to deliver quality outcomes for our local population. We have a limited budget available to us so it is even more important that we use it wisely.

Many of the messages in this section are still in development, as such we intend this document to support further discussion and service development over the coming year.

Key Messages for the Market

Overarching messages

Future demand:

- Demand for care and support services will rise but will not be matched by a similar commitment in public spending
- Demand for person-centred assessment of children's needs and specialist placements will rise but again, will not be matched by a similar commitment in public spending



- Statutory requirement through the Special Educational Needs & Disabilities (SEND) reforms to support young people aged 19-25 with SEND, will ensure appropriate, timely transition arrangements are in place, preparing them for adulthood
- People being supported in the community will have increasingly complex needs – children and young people also have increasingly complex needs (due to advances in medicine and survival rates, improved detection and diagnosis)
- Demand for community healthcare will rise, not only due to the ageing population, but also due to our plans to increase the amount of care and support provided at home or in the local community - as appropriate
- Resources will continue to be prioritised to support those people in the highest need. This may mean that some needs will have to be met in different ways in the future
- ESCC will increasingly provide targeted support to children and young people (CYP) where the need is greatest and will look to and encourage community resources to meet the wider needs of young people.
- Cost pressures from Independent Non Maintained Schools (INMS) specialist placements continues, as we see an increase in the complexity of need and in the number of children who require placements in INMS where our maintained special schools and academies are unable to support their health needs, or where Tribunals have gone in favour of placing in INMS
- The development of the Integrated Locality Teams will mean different commissioning and planning arrangements to be much more tailored to the local communities' needs
- For CYP, parents and carers want wrap around, integrated support – the keyworker model
- All providers of health and wellbeing services should seek to identify opportunities to embed primary prevention, self-care and self-management into their core activity enabling access to services, signposting to community based support and promoting and supporting self-care and self- management across the client pathway
- For CYP with SEND, providers should be inclusive - promoting early intervention and supporting independence to ensure needs can be met within the community
- For CYP specialist services, East Sussex will increasingly look to work with neighbouring authorities to achieve economies of scale and meet quality standards
- ESCC will be looking to ensure support is available for the growing number of vulnerable children and families as a result of domestic abuse and sexual exploitation. This may be commissioned externally across a number of providers or in partnership with other authorities

Current supply:

- Prevention is everyone's business. This means empowering people as far as possible to take control of their own health and wellbeing
- Parents need support and advice on how to encourage intervention for their children
- Providers are expected (through SEND Code of Practice) to identify SEND as early as possible to ensure correct interventions are in place



- Providers are expected to work across the health, social care and wider system to support and enable children, families, clients and carers to make the best use of local community resources and support. The SEND Code of Practice places much emphasis on the local offer – that is the whole system of support for CYP with SEND and their families
- There remains workforce supply and recruitment issues for a range of professional in both health and social care. For example: GPs, nurses, Emergency Physicians, Radiographers, children's therapists, educational psychologists, and wheelchair engineers. Benefits from national workforce planning initiatives are unlikely to be fully realised until 2020, so local recruitment and retention strategies will be key to resolving workforce capacity issues in the short-medium term
- There are currently capacity issues in a number of areas of the domiciliary care market, and a shortage of provision of reabling homcare
- Providers are asked to provide up-to-date information about their services to the Service Placement Team (brokerage function) to help care managers to commission services
- Providers should utilise East Sussex 1Space, a free resource, to make the wider community aware of the services they offer
- Providers should utilise the directory element of the Local Offer, a free resource, to make families aware of their offer
- We will be offering training and skills development in available self care and self management solutions

Opportunities for market development:

- Providers should proactively seek opportunities to link with each other, communities and commissioners to develop and design systems and approaches which support the development of resilient and healthy communities
- Commissioners will be seeking to work with providers able to deliver a 7 day service, this includes assessment and initiation of support at weekends
- Commissioners are interested in working in partnership with providers who could:
 - radically review their service models with the intention of consolidating services into more integrated or larger scale models of support, thereby increasing flexibility and reducing infrastructure costs because of the higher volumes of people being supported
 - maximise alternative funding opportunities or are able to work in partnership to reduce 'back office' costs through initiatives such as sharing back office functions, the resultant shift in resources to direct support for the person with care and support needs
 - work with people with care and support needs and their carers to identify and develop shared interests so that people can participate in leisure and social activities, using support by pooling personal budgets and sharing support hours
 - work with our schools and colleges and provide specialist health support that will benefit all SEND pupils by educating them within their local community wherever possible and promoting their independence
 - seek out innovation in provision, including use of new technologies to support independent living etc.



www.eastsussex1space.co.uk



Key messages for Healthy Living and Wellbeing

Helping all children get a good start in life, preventing ill health, promoting independence and improving awareness of and access to services and activities that support healthy lifestyles, promote self care, maintain wellbeing and make best use of community assets.

Prevention and promoting wellbeing is central to our approach to supporting local people and communities. We are seeking to establish a prevention pathway and within that utilise every opportunity to embed prevention by rolling out Making Every Contact Count (MECC) across the health and social care system, and promote new technologies coming onto the market that can support people to maintain their levels of independence for as long as possible.

For children and young people, healthy living and wellbeing involves early intervention so that future issues are avoided or don't escalate or to maximise the potential of those additional needs, such as children and families with Special Educational Needs and Disabilities (SEND).

We are also working in partnership with the local voluntary and community sector, and communities themselves, to understand how we can grow organisational and community resilience. We want to continue to work together to improve wellbeing through delivery of projects such as Building Stronger Bridges, which seeks to combat social isolation and loneliness through the development of Good Neighbour Schemes, and Chances 4 Change East Sussex which supports communities to develop health and wellbeing opportunities for themselves and their neighbours.

We want to make sure that our services meet the changing needs of local people and are underpinned by knowledge of what works. We recognise that the last financial year has been challenging in respect of the savings consultation and the difficult decisions that have been required to deal with the reduced funding that the Local Authority receives. However, we are committed to the sustainability of the local voluntary and community sector and are keen to explore new ways that we can work in partnership to attract alternative funding streams.

Aims and objectives for 2016/17:

- Embed prevention across the health and social care system by developing a prevention pathway, so that all services and support contribute to improving health outcomes and maximizing potential, whatever the level of need.
- Develop early intervention referral pathways for all CYP including those with SEND, recognising the good practice in early years
- Embed primary, secondary and tertiary prevention across all health and social care activity and prevent or slow down the progression of people with existing health and social care need to higher intensity services
- Maximise use of Telehealth and Telecare (assistive technologies)
- Recognise and work with the diversity of communities, and work in partnership with them to increase the impact that communities make to maintaining and improving health and wellbeing
- Support schools and workplaces to take action to improve health
- Reduce dependence on statutory sector services for low level interventions
- Work with all market sectors to raise and improve awareness of available preventative services across the integrated health and social care economy using EastSussex1Space, Local Offer, Health and Social Care Connect, DXS system and Map of Medicine



- Ensure our lifestyle services are appropriate and meet the needs of our local population
- Implement a full strength and balance exercise continuum to address falls in older people focused on primary and secondary prevention
- Ensure carers maintain their wellbeing (including parents of children with SEND who often do not recognise the “carer” label and young carers)

Progress to date:

- The **Health Help Now** mobile application went live in December 2015. Health Help Now provides a digital solution to increasing access to health advice, guidance and signposting to local services. It uses clinically agreed advice and the NHS 111 directory of services information. It locates the user by using postcodes or mobile phone GPS and signposts them to the most appropriate local service. It provides service details including address, opening times, directions and a map
- **Wellness Recovery Action Planning (WRAP)** is an approach and self-management tool which can be used by anyone. It can help to create positive changes in the way users feel and put in place coping strategies for when people feel they are not managing. We are currently commissioning WRAP training for client groups and carers across East Sussex
- A **primary prevention workshop** was held in December 2015, and was attended by 70+ colleagues from across health, social care, housing, environmental health, voluntary sector and primary prevention service providers. Four strands of primary prevention work streams have been identified and detailed delivery plans against each strand are in development
- The **Wellbeing and Resilience Measure (WARM)** has been utilised to understand the assets in our communities. WARM sets out an approach to measuring the wellbeing and resilience of communities and provides a way of understanding and identifying an area’s strengths (or assets) such as levels of social capital, confidence amongst residents, the quality of local services or proximity to employment; as well as vulnerabilities such as isolation, high crime, low savings and unemployment
- **19 new Good Neighbour Schemes** have been developed across the County through the Building Stronger Bridges Programme
- **Chances 4 Change East Sussex** has been commissioned to improve the health of those most at risk of health inequalities by using asset based approaches to develop and deliver health improvement opportunities and interventions at a local community level
- **8 Locality Link Worker** posts (covering the 6 localities in ESBT, and 2 for the HWLH area) have been funded to link Integrated Locality Teams with communities
- Healthcare providers are being supported to embed **Making Every Contact Count (MECC)** approaches into their services
- A **grants programme to support schools** to develop school health improvement plans and initiatives to improve health in the school setting has been offered to all schools in East Sussex
- A **series of engagement activities and events** has been commissioned to inform work to develop community resilience in East Sussex
- Environmental health colleagues are being supported to develop **a toolkit to support workplace health initiatives**
- The development of **social prescribing** to enable GP practices to easily refer people to a wider range of support to help improve health and keep well



- **A grants programme in Hastings and Rother** to support community and voluntary sector groups to provide access to a wide range of health improvement activities and support

Opportunities for market development:

- We will be offering training and skills development in prevention, self care and self management solutions
- We will be seeking to work with providers to co-design self care solutions such as portals, and information and advice
- We will be exploring potential opportunities to deliver prevention, self care and self management services, including health promotion campaigns, coaching, and infrastructure support
- We will be reviewing models of provision for lifestyle services, including the potential contribution of integrated lifestyle services
- We will be supporting schools and early years settings to identify and act on opportunities to improve health
- We will be reviewing the provision of public health services in pharmacies and General Practices
- We will be looking to develop the market to launch new strength and balance exercise provision and introduce self-referral routes to support earlier identification of individuals who will benefit from intervention
- We will be seeking to commission specialist support to develop an evaluation toolkit for community resilience
- We will be supporting the development of self funding strength and balance exercise classes in the voluntary sector
- We will be looking to commission a special school nursing service to work with our maintained schools to keep children and young people within their communities, promoting their independence and reducing the number of INMS placements

Key messages for Proactive Care

Providing integrated and targeted health and social care services to support children and families in need and people with long-term conditions and illnesses to maintain health and independence for as long as possible, and avoid having to go to hospital or complex accommodation-based care.

With increasing demand and limited resources, we need to find better ways to identify and respond to those most at risk, and with the lowest possible level of intervention appropriate. To support this we have commissioned a new Frailty and Community Geriatrician service.

Service providers play a key role in supporting the most vulnerable members of our community with increasingly complex needs. They are also a key resource in preventing unscheduled admissions to hospital and supporting people to leave hospital and return home.

We want to work with the market to embed best practice and to deliver services that ensure people maintain their health and independence for as long as possible, and prepare for the future and the type of care they may want if their health deteriorates.

Aims and objectives for 2016/17:

- Develop risk stratification tools to support multidisciplinary professionals to proactively identify and support people at risk of deterioration
- Introduce proactive care planning in partnership with GPs for at risk patients, clients and carers
- Streamline care planning processes, utilising the summary care records and additional or enhanced information to do that

Preferred Priorities of Care

The Preferred Priorities for Care (PPC) document is designed to help people prepare for the future. It gives them an opportunity to think about, talk about and write down their preferences and priorities for care at the end of life. See more at: www.nhs.uk/resource-search/publications/eolc-ppc.aspx#sthash.FD71DfUbdpuf

- Ensure learning disability services have implemented the Department of Health (DH) policy 'Positive & Proactive Care' (2014)
- Work with providers to roll out Preferred Priorities of Care documentation in nursing homes, residential homes and domiciliary care settings, and continue to develop tools to meet the needs of those with and without capacity
- Provide comprehensive assessment and reablement during post acute care to determine and reduce long term care needs
- Implement a Fracture Liaison Service (FLS) for the East Sussex population aged 50+ presenting with a new fracture
- Ensure clients residing in care homes are not excluded from rehabilitation
- Target commissioned housing support services at those most at risk in order to maintain health and wellbeing for as long as possible
- Create 8 locality Integrated Service Teams across all East Sussex providing seamless services for families with children aged 0-5
- Work with parents and providers to promote independence for children and young people with long term conditions
- Provide training and support for parents and families of children and young people with long term conditions to support their independence

Progress to date:

- **6 Integrated Locality Teams** have been established in virtual form, working across health and social care with single line management in the Eastbourne, Hailsham and Seaford localities and in Hastings & Rother
- The CCGs are working supportively with **Primary Care** to improve administrative processes to release clinical time to be spent with patients
- Personalised **wellbeing checks** and call reminders are being provided through the existing commissioned telecare service
- **5 Frailty Nurses** have been successfully recruited across East Sussex to proactively support the older members of our community, however attempts to recruit **Community Geriatricians** continue
- From April 2016, locally commissioned services have been agreed for vulnerable adults in **Primary Care** to include avoiding unplanned admissions, advanced care planning and meeting palliative care needs

Opportunities for market development:

- We will be looking to work with services that can provide 'step up' and 'step down', crisis response, emergency placement and short breaks provision in response to changes in need for people with a learning disability and/ or autism who have a mental health condition and display behaviour that challenges – this will also need to involve looking at what the offer will be like for children and young people and their families
- We will be re-commissioning countywide provision of information, advice and demonstrations of adult Community Equipment to sit alongside proposed Occupational Therapist-led community based clinics
- We will be looking at the information, advice and support offer for families of children and young people with SEND
- We will be exploring the benefits of a commissioned Telehealth service to support patients to self-manage and alert an appropriate person to significant risks. We will be looking at how to engage young people with these products and how we can make the products and services interesting to this demographic
- We anticipate an increased role in proactive care for third sector providers, with a greater / more formally co-ordinated role with the statutory sector – particularly for people with mental health issues



- We will be seeking to work with voluntary and community sector providers to identify hard-to-reach groups to proactively engage and work with, including young people that have become disengaged

Key messages for Crisis Intervention and Admissions Avoidance

Ensuring the right services are in the right place at the right time to help people regain their independence and well-being quickly following a period of illness, and to avoid admission into hospital or complex accommodation-based care where unnecessary.

We are looking to establish 7 day access to services across the urgent care pathway in East Sussex. Whilst we are making significant changes to our in-house provision and pathways to make this a reality, we also need to work with the wider market to ensure that the right services are in place within the community to support people when they need it most.

Aims and objectives for 2016/17:

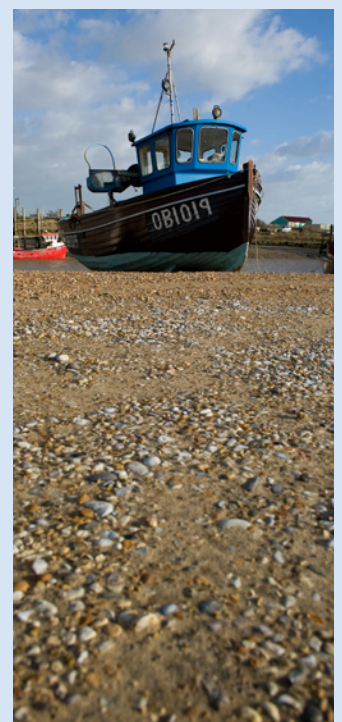
- Deliver 7 day access across the urgent care system in East Sussex and develop and integrate urgent care pathways and services at the front of the hospital
- Embed 24/7 mental health liaison into emergency departments, and ensure the provision of specialist advice and support for urgent and emergency care
- Work with partners to inform development of a sustainable 24/7 medical support model for urgent primary care access
- Create 2 CCG-wide crisis response teams in Eastbourne, Hailsham & Seaford and Hastings & Rother localities, comprising nursing, therapy and healthcare assistant (HCA) support, to reduce presentations and admissions to hospital and prevent re-admissions through the provision of safe alternatives in a community setting, and introduce a Dementia Care Crisis Team
- Reduce ENT non-elective admissions coming through A&E by re-routing suitable patients to a nurse led rapid access clinics
- Review configuration of current commissioned step-up/step-down capacity in the independent sector

Progress to date:

- The commissioned **Carer Respite Emergency Support Services (CRESS)** make sure that short-term support is in place for the cared for person in an emergency. This service is available 24 hours a day, 7 days a week
- **Short term and crisis intervention services** are also currently commissioned through the Red Cross to promote health and well-being to carers and support through companionship, conversation and practical support and/or enabling the carer to take a short break whilst support is provided for the cared for person
- **6 Crisis Response Nurses** and **9 Crisis Response HCAs** have been recruited across the ESBT localities to provide rapid response
- **Take Home & Settle and Home from Hospital services** have been commissioned to provide support for people returning home from hospital, intermediate care and rehabilitative services, and to maintain engagement with their local communities

Opportunities for market development:

- We will be looking to spot-purchase respite provision and additional transitional beds for clients post-rehabilitation, and requiring additional periods of assessment
- We will be seeking to work with providers to extend key provision in the community to operate a 7 day service, where this is not already in place
- We will be looking to work with independent sector providers who are able to assess and begin interventions 7 days a week



- We will be exploring with voluntary and community sector providers, a non-clinical navigator role situated within the hospital to support people to access alternative services and signpost to relevant support
- We will be developing the service specification for 111 in line with national guidance and in partnership with other Sussex CCGs
- We will be exploring technology solutions to access specialist clinical advice

Key messages for Bedded Care

Making sure that people who require in-hospital and complex accommodation-based care receive the best possible services, and only for the amount of time it is required.

The joint vision by 2018 is a shift from reactive to proactive health and social care, enabling people to live in their own home and community for longer with an increased focus on self-care and earlier interventions. However, it is recognised that the need for more complex accommodation-based care will always be required.

The availability of good quality provision in the residential and nursing sector, for example, can help to respond to seasonal pressures, facilitate hospital discharges and prevent hospital admissions, and provide for the increasing complexity of need presented by people living for longer and with multiple long-term conditions.

We recognise that for many providers of more complex community based bedded care the current landscape is challenging, as such we want to utilise our collective resource to support and develop key sectors of the bedded care market in East Sussex.

Aims and objectives for 2016/17:

- Refocus our quality assurance function to provide guidance and support for service providers in the County, particularly around residential and nursing care
- Explore models of residential based care including step up/step down, bed based reablement, care hotel etc. in order to secure options for hospital admission avoidance and early effective discharge
- Consider supporting the better use of Telecare and Assistive Technology within accommodation to make the best use of available resource
- Develop models of accommodation that offer supported living options with shared/communal space for individuals who might otherwise be in residential care
- Develop an accommodation pathway for disabled adults - this will identify clients who may currently be 'over-provided' for due to limited placement options
- Provide quality support to individuals that represent value for money
- Implement performance management of existing PDSI supported living with capital investment to ensure reablement approaches are effective

Progress to date:

- Review of **quality assurance** function is complete, and proposals are being developed to reconfigure the function to best support the market
- **Accommodation and bedded care strategy** development is underway

Opportunities for market development:

- We will be engaging with the market to develop a shared understanding of local business requirements, with support offered to providers who may wish to de-register, resulting in a 'step up, step down' managed model of care, or who require short term respite or temporary care

Care Housing related integration, cooperation and partnerships

Housing and the provision of suitable accommodation is an integral element of care and support. The setting in which a person lives, and its suitability to their specific care needs, has a major impact on the extent to which their needs can be met, or prevented, over time. Housing is therefore a crucial component of care and support as well as a key health-related service.

People with care and support needs may receive support in a wide range of settings during their life. Understanding and linking these settings will help to secure the right accommodation at the right time.

Work is being undertaken to develop a better understanding of the links and dependencies between housing and bedded care in order to identify specific models, services and relationships. This will involve health and social care commissioners, housing, providers and other partners. The development of more efficient systems, innovative solutions and effective partnership working will be actively supported and encouraged.

- We will be seeking to increase the availability of dementia, nursing dementia and behaviours challenging services in the county
- We will be looking to increase the availability of nursing care and domiciliary care in the north of the county and in rural areas
- We will be opening an Approved Development Partners list with a view to developing units of supported accommodation on four sites
- We will be inviting providers who have experience of providing services to the most complex adults with challenging behaviour to join a new framework for provision
- We will be looking for a housing and care and support provider to develop a purpose built supported accommodation scheme for adults with learning disabilities and autism who have the most complex challenging behaviour
- We will be looking for a care and support provider on the ESCC supported living approved list to develop a new supported living service in Seaford
- We will be using the approved provider list for PDSI Supported Accommodation to develop the market and quality of care
- We will seeking to work with providers who actively engage with clients in the development and delivery of their services, working with 'experts by experience' in quality checking service delivery. In learning disability provision, providers may be utilising the Q-Kit or using their own robust systems to ensure that services are person centred and high quality

Key messages for Discharge to Assess

Ensuring patients in hospitals and care homes are discharged as quickly as possible to an appropriate place, with a package of care to support their recovery.

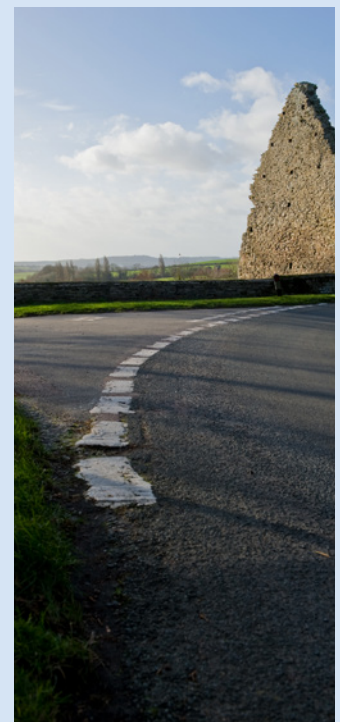
Following an episode of illness, people should be able to return to their own homes as quickly as possible, and with the support they need. As we seek to provide emergency care and support 7 days a week, we will also be looking to work with providers to support discharge from hospital and care homes 7 days a week.

Aims and objectives for 2016/17:

- Ensure access to Home Care and Care Home assessments 7 days a week
- Implement a targeted care home support service to support reduction in falls and fracture incidence in care homes
- Carry out a full service review to inform the development of a business case for future Intermediate Care (IC) and transitional bed capacity and service model from April 2017
- Significantly increase capacity, quality and consistency of community therapy provision (rehabilitation and reablement) in line with evidence to meet projected levels of demand
- Improve recognition of carers, involvement in discharge planning, development of referral pathways
- Implement 7 day pharmacy service to support early discharge
- Integrate commissioning of full range of 'residential' care (from locked rehabilitation to nursing homes, from residential care to supported housing and general needs housing) to speed up access and diversify range required for use

Progress to date:

- Work is underway with providers of home care, residential and nursing care to ascertain interest in collaboratively working to develop **7 day response**
- **Intermediate care service** review underway
- **Patient Pathway Trackers** are being recruited to support effective discharge planning within the hospital setting, and started in post in April



Opportunities for market development:

- We will be exploring the possible commissioning of more step-up/step-down beds located in care homes for dementia patients transferring from NHS beds
- We will be seeking to work with key sectors of the market to ensure that assessments are offered 7 days a week to facilitate hospital discharge
- We will be sharing the outcomes of the Intermediate Care and transitional bed review to inform the market of possible future opportunities for provision in this area

Key messages for Maintaining Independence

Supporting users of health and social care services, and their carers, to live independent lives.

Supporting people to regain and maintain their independence is a key philosophy that underpins the vision for Health and Social Care in East Sussex. People should be enabled to access information and advice about good quality support that is available to help them maintain their independence, and provided with the right equipment and environment to enable them to remain in their own homes. A number of the initiatives referenced in the **Healthy Living & Wellbeing** section can also read across to support this outcome.

Aims and objectives for 2016/17:

- Implement the new Integrated Community Equipment Service contract arrangements to ensure delivery and cover at weekends for urgent equipment orders
- Continue to grow the number of Personal Assistants on the East Sussex Support with Confidence scheme
- Support the development of Good Neighbour Schemes through the Building Stronger Bridges programme
- Review the content and design of East Sussex 1Space to ensure that it can provide the right information and advice to people

Progress to date:

- A **FlexiCheck** service is currently being piloted to determine whether the TeleCheck service can be adapted to support carers who need short term respite solutions
- There are currently 148 approved members of the **Support With Confidence** scheme, of which 76 are Personal Assistants
- There are currently 26 operational **Good Neighbour Schemes** in the county that are supporting their local communities
- There are over 2000 care, support and wellbeing services on **East Sussex 1Space** from Personal Assistants offering a range of help at home to befriending groups, help with pets to healthy activities and support to stay independent and connected to the community
- A **Living Well and Stroke Support** service has been commissioned across the County to provide support to people to maintain their independence

Opportunities for market development:

- We will be procuring the Bespoke Adaptation Service from 2017 onwards through a mini-competition exercise under the Council's Sussex Cluster Framework for building contractors
- We will be seeking to significantly increase the use of Direct Payments and the development of Personal Assistants to offer choice and affordable care, alongside respite for Carers



- We will be exploring the use of existing and mainstream community resources that can be adapted and adjusted to meet the needs and wishes of disabled people
- We will be seeking to work with development proposals that maintain or increase the independence of people with a learning disability, therefore addressing issues of social isolation and reducing a dependence on or requirement for paid support – this would include employment, training, volunteering and work opportunities along with initiatives and projects that enable adults to be more involved in their community

Key messages for Prescribing

Ensuring people receive effective and appropriate medicines when they need them, and reducing the amount of medication that is not taken as prescribed.

We are seeking to work with and support all providers to ensure that people get the best quality outcomes from their medicines. We are exploring new systems and technologies to support people to improve the management of their medication.

Aims and objectives for 2016/17:

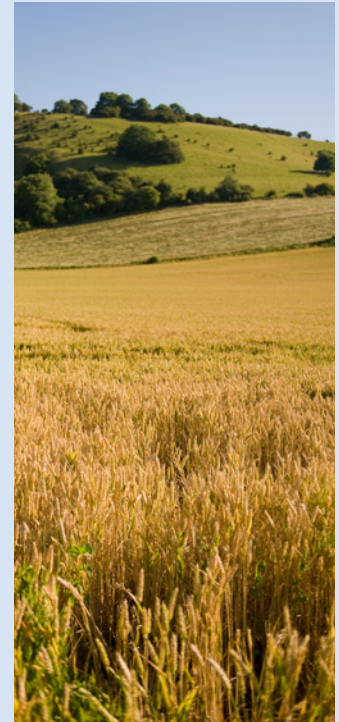
- Implement provision of Medicines Optimisation Service to care homes, to carry out patient-centred clinical medication reviews as part of the Advanced Care Planning process. A technical service will support care home providers to optimise their use of medicines and comply with national standards for managing medicines.
- Improve the quality and safety of the repeat prescribing process by:
 - Increasing the efficient use of electronic prescribing
 - Improving communication between prescribers and community pharmacists (or practice dispensers) to allow them to better support people to take their medicines as prescribed
 - Engaging patients in the co-design of patient information to reduce medicines waste and improve outcomes from medicines use
- Develop a GP Prescribing Support Scheme (PSS) to incentivise reductions in variations in practice with particular focus on reducing variation in the quality of antimicrobial prescribing, prescribing in pain management, woundcare and nutrition.
- Continue to work collaboratively with all providers to support safe and cost-effective use of medicines through our East Sussex Health Economy Formulary and other joint medicines policies.
- Extend TeleCheck to patients who need support to improve medication management, and who would benefit from reminders to take their medication
- Consider development of a Locally Commissioned Service (LCS) with pharmacists to support improved medications managements, e.g. by filling medication dispensers for clients who do not have an unpaid carer or meet disability thresholds that require a pharmacist to fill the dispenser

Progress to date:

- The contract for the **Medicines Optimisation Service to Care Homes** has been awarded to Sussex Community NHS Trust and will be live from April 2016

Opportunities for market development:

- Voluntary and community sector engagement in public campaign to raise awareness of medicines waste issues



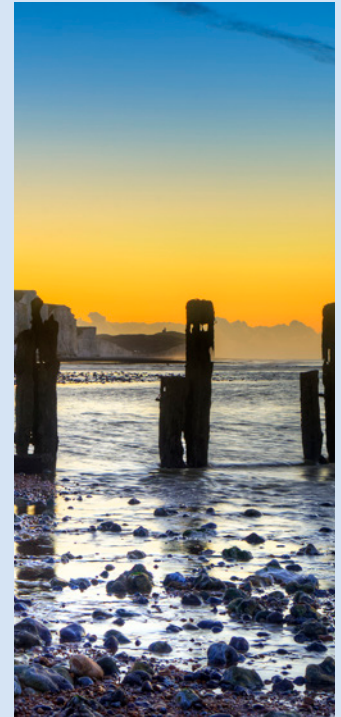
Key messages for Elective Care

Streamlining planned care to ensure local people have choice and are able to make informed decisions about their care.

We want to ensure that people receive treatment and care in the most appropriate setting, that choice is available, and that shared decision making encourages people to be involved in managing their own health.

Aims and objectives for 2016/17:

- NHS Rightcare variation management/reduction – identification of specialities where high levels of activity needs to be reduced to the national lower quartile. Working with practices to manage elective activity and reduce variation
- Surgical thresholds – reducing procedures of limited clinical value to ensure patients are treated in the most appropriate care setting
- NHS Rightcare variation management/reduction – identification of specialities where activity needs to be reduced to the lower quartile
- Surgical thresholds – reducing procedures of limited clinical value and reduction in surgery
- Shared decision making – activating patients to become more involved in their own health and working with GPs to ensure they are making choices with the patients as to the outcomes of the consultation
- Gastroenterology – focus on moving management of Irritable Bowel Syndrome to primary care
- Diabetes – improvements in integrated working between primary care and diabetes specialists; and supporting people with complex needs in primary care with the support of specialists
- Cardiology – improvements in integrated working between primary care and cardiology specialists; earlier intervention, diagnosis and management so that people can be supported in out of hospital settings, closer to home
- Neurology – a review of rehab and intermediate care services, headaches, epilepsy and botox injections and further development of the specialist physiotherapist role
- Ophthalmology – focus on delivering ophthalmology services in the community



Next steps

The commissioning landscape is going to change significantly over the next 2 years and providers from all sectors will need to be supported to adapt. This document is intended to support discussion and debate in the coming year to ensure that together we are able to develop a sustainable service offer, and continue to deliver quality outcomes for our local population.

There are a number of important programme milestones to meet in 2016/17 as we move towards test phase Accountable Care in April 2017, including the development of a single planning and commissioning process across the ESBT health and social care economy by June 2016 enabling collective decision-making about the shared £800m resource and aligned to the 6+2 box model.

The ESBT programme has acknowledged from the beginning that the best solutions can only be arrived at by working together, as such engagement across all stakeholder groups has been an important part of programme shaping and delivery to date and will continue to play a key role in helping us to deliver the next phase.

There are a number of opportunities coming up over the next couple of months for providers from all sectors to get involved in the programme:

- **June 2016:** Locality Engagement events across the county

We will also be continuing the conversations through our existing provider forums and networks.



For more information about any of these events and for instructions on how to book a place, please go to: <http://news.eastsussex.gov.uk/east-sussex-better-together/events/>



Appendix 1: Procurement plan

Service Name	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrated Community Equipment																
Integrated Sexual Health Services																
Sex and Relationship Education																
Drug & Alcohol Rehabilitation Services																
Specialist Smoking Cessation																
Health Trainer Service																
Tier 2 Weight Management Services																
Floating Housing Support																
Supporting People Service																
LD Residential Care & Support in H&R																
Care at Home Services (South East)																
WAA Supported Living Approved List																
Challenging Behaviour Services																
OP Nursing and Residential Preferred Providers																
WAA Nursing and Residential Approved List																

KEY

- Based on current contract expiry date
- Date if an option to extend current contract is used



For more information about this document or for any queries please contact:

Bianca Byrne
Acting Head of Policy & Strategic Development
Adult Social Care and Health
01273 336656
Email: marketpositionstatement@eastsussex.gov.uk

East Sussex County Council

County Hall
St Anne's Crescent
Lewes BN7 1UE
Phone: 0345 60 80 190
Fax: 01273 481261
Website: eastsussex.gov.uk/contactus

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