Agenda Item 7

Report to:	**Adult Social Care Scrutiny Committee**
Date:	**4 March 2010**
By:	**Director of Adult Social Care**
Title:	**Refresh of Joint Older People's Commissioning Strategy**
Purpose of Report:	**To update the committee on progress of the Strategy which will deliver a 'fit for purpose' joint commissioning plan and meet both national and local priorities of older people and their carers in East Sussex**

RECOMMENDATIONS

The Adult Social Care Scrutiny Committee is recommended to:

1. consider and comment on the contents of report; and

2. support the proposed approach, framework and timetable for the refresh of the strategy

1. Financial Appraisal

1.1 Financial commitments to deliver the strategy will be within existing financial resources. Details of the allocation of these resources will be in the strategy's action plan.

2. Background and supporting information

2.1 In 2007 East Sussex published its first Joint Older People's Commissioning Strategy. This strategy detailed the ambition of East Sussex County Council, the NHS in East Sussex and a range of partner organisations in the voluntary and independent sector to work in partnership with older people and carers to improve the experience of people who use our services and to get the most out of available resources. A three year action plan was developed and implemented to help us achieve this aim.

2.2 The implementation of the action plan was achieved through the establishment of six steering groups. Each steering group was responsible for the work associated with each of the five stages of the 'care pathway' and an additional steering group was established to oversee the work involving mental health issues in later life. The areas of work covered by the six groups are shown below:

- Fit and well and growing older
- Experiencing problems that might be preventable
- In immediate need of help or treatment
- Ready/preparing to go home
- In need of long-term support
- Mental health in old age

2.3 Further to a review of the governance arrangements it was decided that two of the steering groups should report to other key strategic bodies and that work of two groups should be combined. The three steering groups which oversee the continued implementation of the work of the strategy are:

- Promoting Healthy Older Age and Long Term Independence and Community group
- Hospital Discharge group
- Joint Older People's Mental Health Commissioning group

2.4 We published a booklet called 'Success and opportunities' 2007/09 in September 2009 (copy attached) which gives a brief update of what we have achieved so far, what we still need to do and our proposals for developing services in the future. We now want to build on these achievements and put into action what we still need to do.

3. Proposed approach

3.1 The aim will be to develop a 5 year joint older people's and carers commissioning strategy to cover the period 2010/15 which sets out future purchasing and service provision arrangements/ intentions in order to meet both existing and future social care, health and housing needs of older people and carers who reside in East Sussex. To achieve this the strategy will:

- build on the work and achievements of the current strategy
- take into account impact of both national and local priorities including those identified in the East Sussex Integrated Health & Social Care Well-being Plan (currently being developed)
- take into account the six dimensions developed by CQC for the assessment of quality in health and social care

4. Format and framework of strategy

4.1 It is proposed that the Strategy will consist of three main documents:

- Detailed body of evidence which will bring together key information and work which will identify priorities and outcomes of strategy

- Summary document- this will be a shorter version of the above document aimed at a wider audience - will be published in booklet format similar to style of booklet 'Success and Opportunities' referenced in 2.4 and will be the public face of strategy (30 pages maximum). Please see appendix 1 – this is an early draft document which is a 'work in progress' and outlines a proposed approach and format.

- Commissioning action plan- will include SMART targets and link to achieving priorities and outcomes- will include financial investments- suggest three/five year action plan with annual milestones- to be updated on an annual basis.

5. Development of Strategy and timescales

5.1 The strategy will be developed using a project management approach. The development of the strategy and its subsequent implementation will be overseen by the Older People's Partnership Board (draft project initiation document is available on request). Timescales are summarised below:

Task	**Date by**
1st Draft of strategy circulated for consultation	April 2010
Final draft of strategy	July 2010
Strategy published	August 2010

6. Conclusion and reasons for recommendations

6.1 The East Sussex Joint Older People's Commissioning Strategy 2007/10 has successfully achieved some key objectives in improving the delivery of services for older people and their carers in East Sussex. Over the last two years there has been significant progress both nationally and locally in driving forward changes and improvements in services for older people and their carers in social care, health and housing support services.

6.2 To build on these achievements and ensure that partners in East Sussex continue to embrace these changes and improvements together with older people and their carers it is proposed we work together to set our commissioning intentions for 2010/15 and adopt the above approach to successfully do this.

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Local Members: All

Background Documents: East Sussex Joint Older People's Commissioning Strategy 2007/10

Joint Commissioning Strategy for older people and their carers

1. Introduction

This five year commissioning strategy sets out our future purchasing and service provision arrangements and intentions in order to meet both existing and future social care, health and housing support needs of older people and their carers who reside in East Sussex.

The strategy has been developed in partnership with older people and carers, the NHS in East Sussex, the district and borough councils and a range of voluntary and independent organisations. The aim of the strategy is to respond to the changing needs and expectations of older people and carers.

It describes how health, social-care and housing support services will change in the next few years, taking into account national and local priorities and the views of older people and carers.

2. Background

In 2007 East Sussex published its first Joint Older People's Commissioning Strategy. This three year strategy detailed the ambition of East Sussex County Council, the NHS in East Sussex and a range of partner organisations in the voluntary and independent sector to work in partnership with older people and carers to improve the experience of people who use our services and to get the most out of available resources. A three year action plan was developed and implemented to help us achieve this aim.

The implementation of the action plan was achieved through the establishment of six steering groups. Each steering group was responsible for the work associated with each of the five stages of the 'care pathway' and an additional steering group was established to oversee the work involving mental health issues in later life. The areas of work covered by the six groups are shown below:

- Fit and well and growing older
- Experiencing problems that might be preventable
- In immediate need of help or treatment
- Ready/preparing to go home
- In need of long-term support
- Mental health in old age

The table in appendix A shows the different stages and examples of what people may experience at each stage. Each group reported on the progress of the targets in their action plans to the Older People's Partnership Board (OPPB) on their progress every three months and on an annual basis. The board has representatives from the primary care trusts (PCTs), Adult Social Care (ASC), acute hospitals trust, mental-health trust, housing partners, chosen representatives for older people and carers and the voluntary sector.

The board is responsible for making sure the work of the strategy stays on track and makes a real difference to older people's and carers' lives.
Further to a review of the governance arrangements it was decided that two of the steering groups should report to other key strategic bodies and that work of two

groups should be combined. The three steering groups which oversaw the continued implementation of the work of the strategy were:

- Promoting Healthy Older Age and Long Term Independence and Community group
- Hospital Discharge group
- Joint Older People's Mental Health Commissioning group

On an annual basis we reviewed our action plans taking into account both local and national priorities. In September *2009* we published a booklet called' Success and opportunities' 2007/09 which gives a brief update of what we have achieved so far, what we still need to do and our proposals for developing services in the future.

3. The development of the strategy

It has been acknowledged by partners and older people and carers that as with all strategies the objectives and targets of the 2007/10 strategy have evolved over time and been updated to take into account changes in both local and national circumstances and initiatives. We have already successfully achieved many of our objectives and have incorporated the impact of significant external influences which have changed the way in which we will be commissioning services in the future. The most significant of these being the Putting People First concordat in 2007, World Class Commissioning in 2008 and the global and national economic downturn in early 2008.

Partners and older people and carers have been actively involved in both the implementation and updating of the 2007/10 older people's commissioning strategy. On an ongoing basis we have sought their views through partnership meetings, engagement and consultation events. This has included:

- Supporting People cafes- 2009,
- Long term independence workshop - 2008
- Emergency care network workshop - 2008
- Older People's engagement events in 2008 and 2009
- Health and Social Care Closer to home events in 2007, 2008 and 2009
- Putting People First brokerage workshops in 2009

This has ensured that partners and older people and carers have influenced decisions on our future priorities and our changed approaches to the governance of the implementation of the strategy. We are committed to retaining this inclusive approach and have used the views of partners and older people and carers to inform and develop the new strategy.

4. Our vision for the future

Over the last three years there has been significant progress both nationally and locally in driving forward changes and improvements in services to older people through:

- the review of health and social care services and the adoption of new goals

- recognising the importance of other key services beyond health and social care in improving the well being of older people and carers

- successful partnerships and the active engagement of older people and carers

We now want to make sure that we build on our achievements locally and plan what we need to put into action from 2010 onwards.

The County Council, NHS East Sussex, district and borough councils, voluntary and independent sector partners are at the forefront of dealing with the implications of an aging population. By working with and listening to older people and carers we are aiming to re-define their role and place within local communities by moving away from negative stereotypes of dependence to a more positive appreciation of knowledge, skill and experience possessed by older people.

Significant joint work has been carried out in East Sussex to improve the range and quality of health, social care and housing and support services. A number of local joint strategies and plans have been developed which will complement the development of the new older people's commissioning strategy for the following groups/ key areas of work as follows:

- Carers
- Adults with physical impairments, sensory impairments or long term conditions
- Supporting people (Housing related support)
- Older people with dementia

To enable us to successfully work together to achieve our aims we have identified and agreed a joint vision, key priorities and identified underlying principles.

Vision

To make East Sussex a safe, healthy and enjoyable place to live for older people and their carers by:

- enabling them to live their lives with dignity and independence
- improving their quality of life and well being
- supporting them to access a range of good quality care and support services that provide good value for money

Priorities

- Improve the range of community services and make them easier to access.

- Improve accommodation options, with more community-based services and supported housing;

- Increase re-ablement[1] services in the community

Principles

[1] Re-ablement is the provision of short-term intensive support, often following an illness or accident. It aims to help people live as independently as possible in their own home.

- Services are in place for each stage of the care pathway
- Value for money and efficiency within available resources
- More integrated and co-located health, social care and housing services
- Reduce independence on hospital and long term care
- Support people to take control of their own health and social care needs
- Commissioning high quality personalised services
- Reduce inequalities
- Support market development and joint commissioning of services by health, social care and housing
- To meet both current and future needs and demand
- Continue shift from residential to community based services

5. Refocusing the approach- national and local drivers

In recent years a number of national and local initiatives have stimulated a whole new approach to the way in which services are developed, the role of older people and carers in deciding what services they need and how these will be purchased and managed.

These initiatives promote a move away from a focus on a limited number of services aimed at primarily older people most in need to an increased choice of services which focus on a more proactive approach to targeted prevention to a larger number of older people with a range of needs. This will help people to continue living independently and enjoy a better quality of life.

These changes can only be achieved by all services and partners working together with older people and carers.

National Initiatives

Building on the overall direction and priorities outlined in the Government White Paper ' Our Health, Our Care, Our Say: A new direction for community services' (2006) we have seen the publication of key strategies/initiatives which will determine the future development of services for older people and carers in East Sussex. These are summarised below:

Putting People First (PPF) – a shared vision and commitment to the transformation of Adult Social Care (2007)

The PPF programme is the largest transformation of adult social care since the NHS and Community Care Act was introduced in 1990.

The Government is clear that putting power in people's hands is the way forward for social care. One of the main ways it is going to achieve this is through a new approach called Personal Budgets and Self Directed Support.

There are four central components of Putting People First. These are:

Universal Services – these are the general support and services available to everyone locally including things like transport, leisure, education, health, housing, community safety and access to information and advice. These services are important in everyone's lives, not just those people with care and support needs. Universal services work best when everyone can get the information, advice and

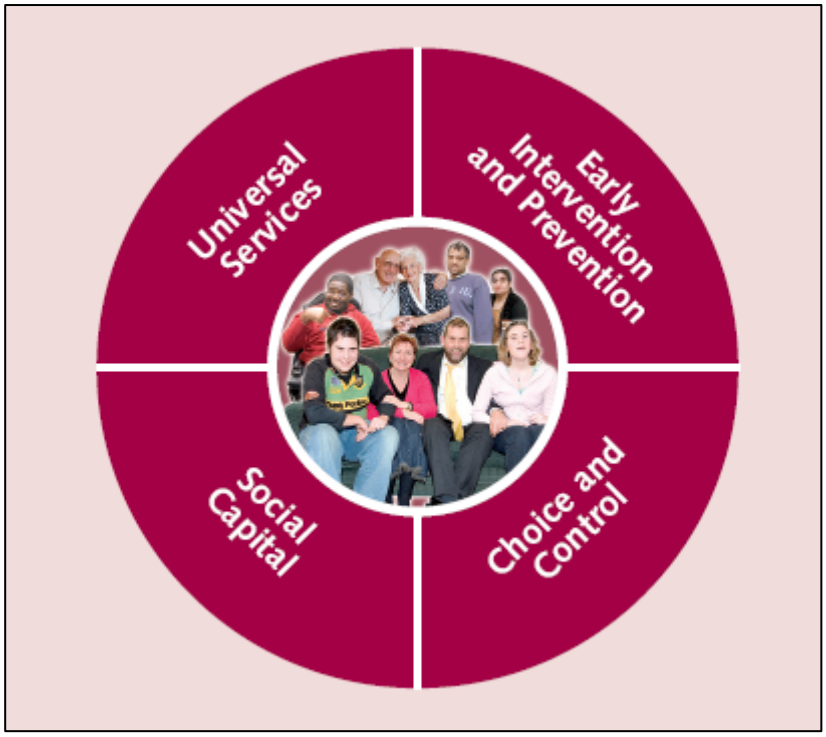
support they need readily and easily to be able to use them effectively. They can then maintain their health and wellbeing, exercise choice and control over their everyday lives and participate

- **Prevention and Early Intervention** – This has three elements:

  - Primary – maintaining good health and independence of the community in general

  - Secondary – identifying people at risk and slowing or stopping deterioration (also described as early intervention)

  - Tertiary – minimising deterioration or disability from existing health conditions. This principle should underpin ongoing case management



- **Choice and Control (Self Directed Support)** – services available to meet people's needs rather than people having to fit in with the things on offer; making sure people have greater choice and control over their lives, including choice and control over the support they receive and what it aims to achieve

- **Social Capital** –developing the community and encouraging people to make use of all resources available to them in the community, through their own personal networks (family and friends) as well as different types of community groups and the voluntary sector. It also captures the support for family and carers to help them be an effective part of the support network.

World Class Commissioning (2008)

The vision for World Class Commissioning is a shared vision. It has been developed by the wider health and care community and will be delivered by the NHS at a local level. As the main healthcare commissioners, PCTs will lead the work to turn the world class commissioning vision into a reality, and to apply it in a way that ensures the needs and priorities of the local population are met. This will be achieved through building close relationships with key local partners, including patients, the public, local authorities, and providers, clinicians. Clinical involvement, in particular, will be key to success.

World Class Commissioning (2008) sets out a series of goals that will enable local NHS organisations to commission services that will deliver the highest quality care and support.

1. Demonstrate local leadership of the NHS.(WCC-C1)
2. Work collaboratively with partners to commission services that optimise health gains and reductions in health inequalities. (WCC-C2)
3. Seek meaningful engagement with the public and patients. (WCC-C3)
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality.(WCC-C4)
5. Manage knowledge and undertake robust and regular needs assessments.(WCC-C5)
6. Prioritise investment according to local needs.(WCC-C6)
7. Stimulate the market to meet demand and secure required outcomes. (WCC-C7)
8. Promote and specify continuous improvements in quality and outcomes through innovation.(WCC-C8)
9. Secure procurement skills that ensure robust and viable contracts. (WCC-C9)
10. Ensure contract compliance and continuous improvements in quality and outcomes. (WCC-C10)
11. Make sound and sustainable financial investments.(WCC-C11)

National Strategy for Housing in an Ageing Society (2008)

Key areas covered in strategy are:

- National information and advice service
- More mainstream housing options
- Improved Planning systems
- More specialised housing options
- Future HIA project
- Improved DFG
- Joined up health, housing and care preventative services
- More housing options including equity release, home-share, moving on and home audit

The Government's national strategy for housing in an aging society launched in February 2008 challenges everyone concerned with the delivery of housing, planning and associated services to respond to 'one of the great challenges for housing in the 21st Century, an ageing population'.

The strategy looks at what can be done now to address he current needs of older people. Improving their opportunities and providing better choices, including the option of staying independent for as long as possible. This includes the provision of repairs and adaptations to existing stock, advice and information, home improvement agency services and preventative technology.

Secondly it looks at future requirements for an ageing society with improved benefits for all. Encompassing planning and new supply, lifetime homes, lifetime neighbourhoods, specialist housing that provides variety and choice and inclusive design, both within and outside the home. It outlines the need for a joined up response across housing, health and care provision. The strategy will impact not only on specialist housing and related service provision but also services and adaptations for people within their existing homes, often within general needs housing.

It also launches a debate on what we want for ourselves in terms of housing for the future, challenges thinking about older people as dependent and the medical model. Embodied by products & services which belong in hospital not homes!

National Dementia Strategy (2008)

National Carers Strategy, Carers at the heart of 21st century families and communities (2008)

Sets out a vision for the future care and support of carers for the next 10 years. The main aims nationally for adult carers are set out as follows:

- Carers will be respected as expert care partners
- Carers will have access to the integrated and personalised services they need to support them in their caring role
- Carers will be able to have a life of their own alongside their caring role
- Carers will be supported so that they are not forced into financial hardship by their caring role
- Carers will be supported to stay mentally and physically well and treated with dignity.

This document was produced after extensive national consultation, and builds on the key needs identified in the Kings Fund Carers' Compass. It also updates the definition of a carer to include those caring for a relative, partner or friend with mental health or substance misuse problems.

Lord Ara Dazi's Next Stage Review
To insert
Green Paper on future funding of care services 2009
To insert

Integral to the monitoring of the implementation of some of these initiatives is the establishment of a new organisation called the Care Quality Commission (CQC) to regulate the quality of Health and Social Care and look after interests of people detained under the Mental Health Act in England. The CQC brings together the Commission for Social Care inspection, the Healthcare Commission and The Mental Health Act Commission. They look at a joined up picture of health and social care

'To ensure better care for everyone in hospital, a care home and at home '

<u>Local initiatives and strategies</u>

There are also a number of local strategies and initiatives which have informed the development of this strategy. The most significant of these are the The Health and Wellbeing of older people- Director of Public Health Annual Report 2009/10 and the East Sussex Integrated Health & Social Care Well-being Plan (currently being developed).

The Director of Public Health report brings together key information on older people living in East Sussex including data on the population and life expectancy, pattern of illnesses, activities to promote a healthy old age and a range of quality initiatives taking place. A subsequent analysis of this information produced some key recommendations to inform the future commissioning of services for older people and these have been incorporated into the strategy.

East Sussex Integrated Health & Social Care Well-being Plan is in the process of being developed. This plan will build on the strengths of the existing County partnership arrangements and bring together the shared priorities and joint commitment of Adult Social Care, Primary Care Trusts, Children's services and the County Councils executive department to deliver them.

NHS East Sussex Downs and Weald and Hastings and Rother Commissioning Plans

The Strategic Commissioning Plans review the East Sussex population's current health, and healthcare needs, and look at the initiatives designed to improve health and well being. They review the current and future assumptions for service change, and delivery, plus the financial forecasts associated with the same. They also review the challenges and opportunities for the PCTs as they strive to become World Class Commissioners (see Section 4.5), with the opportunities for staff development and Organisational Development designed to support this change.

The key strategic goals within the Strategic Commissioning Plans are identified as:

- Reduce health inequalities and improve life expectancy by focusing up on vascular disease and infant mortality;
- Increase the detection, management and treatment of chronic diseases;
- Improve health by reducing smoking, improving diet and exercise, promoting sensible drinking, improving sexual health, improving mental health and ensuring health protection measures.
- Increase investment in services for older people (including rehabilitation and well-being services)
- Improve mental health and well-being.

East Sussex Time of Our Lives Strategy

To insert

Supporting People Commissioning project for older people

To insert

East Sussex Sustainable Community Strategy 'Pride of Place' 2008/26

Within East Sussex the six local authorities have worked together to produce one, integrated Sustainable Community Strategy - Pride of Place[2].

Pride of Place sets out a long term vision for improving people's quality of life and creating strong communities within and across East Sussex. It focuses on the issues and priorities that local people have said they are most concerned about, like crime, housing, education, jobs and the environment. It also sets out the key things we must tackle to achieve the vision. Pride of Place sets out a shared vision for East Sussex in 2026 to create places where everyone can prosper, be safe and healthy, and live in a high quality environment.

The strategy contains countywide strategic objectives and priorities to help achieve this vision. There are also detailed sustainable community strategy chapters for each of the districts and boroughs within the county, setting out a clear local vision, local objectives and local priorities.

2 Pride of Place; Working Towards a Better Future for Local People and Local Communities - A Sustainable Community Strategy for East Sussex 2008-2026

The East Sussex Local Area Agreement (LAA)
This is one of a number of 'action plans' that will help deliver the Sustainable Community Strategy for East Sussex, 'Pride of Place'. Increasing the numbers of people supporting to live independently at home (measured through National Indicator 136) and increasing support and advice and information available to carers (measured through National Indicator 135) are two of the areas for improvement contained within the LAA.

6. Scope of strategy

This commissioning strategy will consider multi-agency existing and new services required to support identified and desired outcomes for older people and carers in East Sussex within known financial constraints.

The strategy will cover people from aged 50 and their carers which will include:

- People with mental health issues (both organic and functional)
- People from Black and minority ethnic, Lesbian & Gay and Transgender and bisexual communities

The strategy does not cover:

- Working age adults with mental health needs, learning disabilities and physical disabilities
- People placed in acute hospital settings
- *Development of specialist services for older people with learning disabilities*

7. What people have told us

To insert summary of feedback from consultation events/surveys with older people and their carers and other stakeholders and show how this has informed priorities

8. Needs/demand assessment/profile of older population

Proposed information to include;

Population
Table - East Sussex and 5 district and boroughs
50- 65, 70-74, 75-79, 80-84, 85 +, 65 +*
Numbers* and %

As above for people from BME backgrounds*

Projected increase over next 5-10 years – 50- 65, 65+ 85+ ?

% of population by electoral ward
Should this be 50 + 65+* 85+*

Income deprivation
50 - 60, 60 + ?* by electoral ward

Carers 50 + and 65+ **

% of households with a least one person of pensionable age that are single occupancy*

Number of carers 50- 64, 65 +- district and boroughs

number of people diagnosed with dementia and prevalence data **

Limiting long term illness** 65 +

Life expectancy at age 65 *- district borough, East Sussex and England

Health issues – stroke, falls, dementia , COPD, Cancer, diabetes* – summary of info from PH report

Info on people accessing services- numbers and type- 65 + ?

- Adult Social care
- A&E*
- Mental health admissions*
- NHS Community services
-

Adult Social Care commission or provide a range of services.

Table 1 provides a summary of the services people receiving via Adult Social Care from July 08 to June 2009***.

Table 1	
Type of Service	**65+ years**
Community Equipment/Adaptation	5210
Home Care	3686
Direct Payment[3]	451
Day Opportunities	929
Meals in the community	1263
Short term residential respite	836
Professional Support	4541
Residential Care	1428
Nursing Care	1221

In include issues/gaps identified in equalities impact assessment

* *info in public health report for 65 +*
** *info in day opps demand/supply mapping report*
*** info from Life Chances Strategy

9. Current services/ market

Summary of current services and costs (could be shown in pie charts) range of providers, current market/ gaps

3 Direct payments are cash payments made to individuals who have been assessed as needing services, in lieu of social service provisions.

10. Future service priorities and commissioning intentions –
These should link back to vision and priorities and will shape action plan and use of resources – also show pattern of resource allocation and how this will change

11. Making it happen
Implementation, governance and monitoring arrangements

eastsussex.gov.uk

East Sussex
County Council

Success and opportunities – two years on

Joint Commissioning Strategy for Older People and carers
Summary report 2007 to 2009





East Sussex Downs and Weald NHS
Primary Care Trust

Hastings and Rother NHS
Primary Care Trust

Contents

Success and opportunities – two years on

Joint Commissioning Strategy for Older People and carers Summary report 2007 to 2009

Introduction

In 2007 we published our first Joint Commissioning Strategy for Older People and Carers. This strategy explained our aim, and the aim of the NHS in East Sussex and a range of voluntary and independent organisations to work with older people (usually people over 65) and carers to improve the experience people who use our services have, and to help us get the most out of the resources that are available.

The strategy describes how health, social-care and housing support services will change in the next few years, taking into account national and local priorities and the views of older people and carers. We put together a three-year action plan to help us improve services for older people and carers by promoting independence and well-being, providing local services and helping people stay in their own homes.

This booklet includes a brief update of what we have achieved so far, what we still need to do and our plans for developing services in the future by building on our current success and taking new opportunities.

National and local initiatives

Over the last two years we have made significant progress nationally and locally in driving forward changes and improvements in services for older people by:

- reviewing health and social-care services and setting ourselves new aims;
- recognising the importance of other services outside of health and social care which improve the well-being of older people and carers;
- working well with everyone involved in planning and providing services for older people and their carers; and
- working more closely with older people and their carers.

Nationally, the following three documents have been published, and these affect how we will develop services for older people in East Sussex in the future.

- Putting People First – a shared vision and commitment to the transformation of Adult Social Care (2007).
- World Class Commissioning – a programme for transforming the way health and care services are commissioned (2008).
- National Strategy for Housing in an Ageing Society (2008).

These documents have influenced our work and will continue to do so in the future.

The documents have also helped us identify the following important aims for local communities.

We must:

- improve people's health and well-being;
- provide health, social-care and housing services which are better linked to each other;
- support more people to live at home and reduce the number of people who are in hospital and long-term care;
- support people to take control of their own health and social-care needs by providing them with support and their own personal budgets to do this;
- develop high-quality services that meet people's needs;
- make sure that everyone can receive that support they need;
- support health and social-care services to make sure there is a wide range of services available that meet people's current and future needs and demand; and
- continue to provide more care and support services in the local community and people's homes (so they can live independently), rather than providing residential care.

Also, a new organisation has been set up called the Care Quality Commission (CQC). The CQC is the independent regulator of all health and social care in England. Their aim is to make sure there is better care for everyone in hospital, care homes and at home.

> **More facilities to help older people remain in their home**

> **Let older people know exactly what is available to help them**

How we have worked together to make sure we achieved our goals

The Care Pathway

Locally, we have worked to make sure we achieved our aims for improving services for older people and carers. We recognised that people would need services at different stages of their lives, depending on their health, social-care and housing needs. To make sure we are able to respond to people's needs at the right time, we identified these different stages and planned how we should change and deliver services at each stage. We call these stages a 'care pathway' and they are shown below.

- Fit and well and growing older
- Experiencing problems that we are able to prevent
- Needs help or treatment
- Ready or preparing to go home
- Needs long-term support

Also, we understand that people can have mental-health issues later on in life, which may or may not be related to their age and which could happen at any of the above stages. We decided we needed to make sure that we planned and improved services to deal with these issues at each stage. We identified this work as an important care pathway called 'Mental-health problems in old age'.

Even though it is clear for us to think about using these stages, we also recognised that people may move from one stage to another and back again, depending on their needs. And, in some cases, it was important to have services to try to prevent this from happening unnecessarily (for example, going back into hospital).

The table on page 8 shows the different stages and examples of what people may experience at each stage.

Making it happen

We set up groups of people from the important organisations who had agreed to work together, and each group became responsible for the work in each stage. This meant we could make sure there would be a complete range of services for each stage.

Each group reported to the Older People's Partnership Board (OPPB) on their progress every three months and every year. The board has representatives from the primary care trusts (PCTs), Adult Social Care (ASC), acute hospitals trust, mental-health trust, housing partners, chosen representatives for older people and carers and the voluntary sector.

The board is responsible for making sure the work of the strategy stays on track and makes a real difference to older people's and carers' lives.

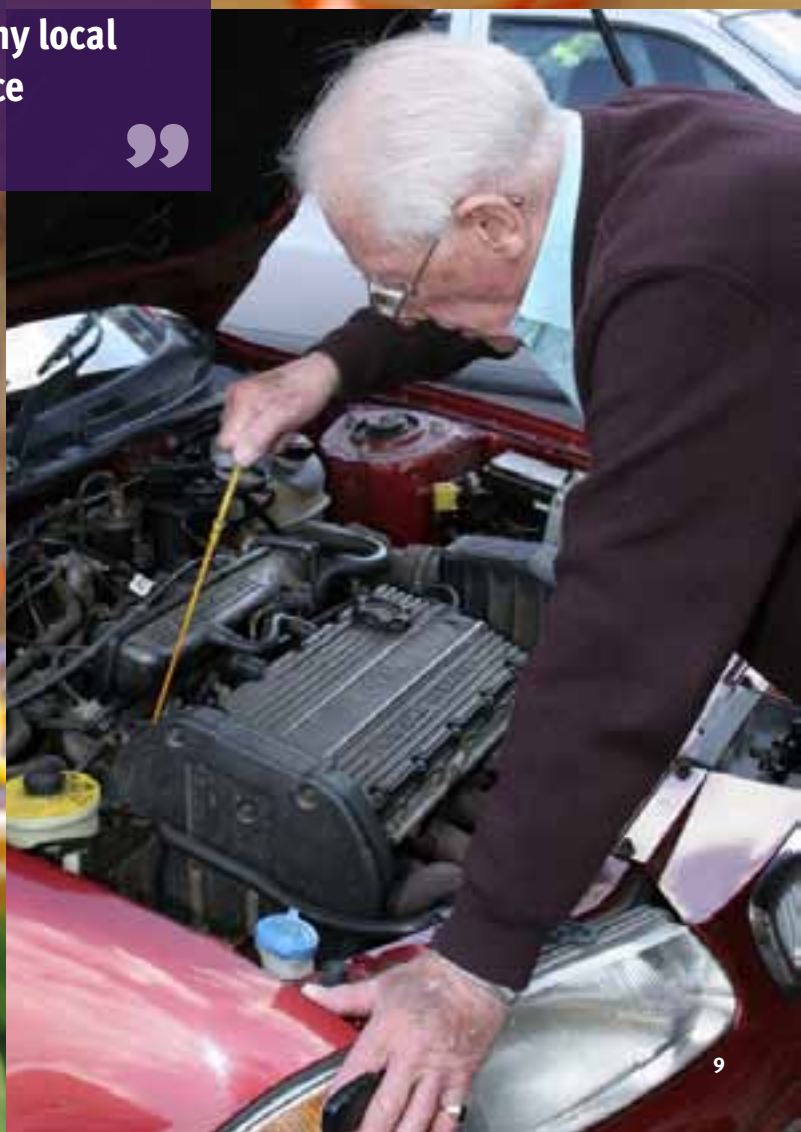
What we have achieved so far and our next steps

The following are examples of what each group has achieved in our first two years of working together in this way and what we plan to do next.

Continued on page 11 ▶

The stage	What people may experience
Fit and well and growing older	People are generally in good physical and mental health and have a good quality of life. They may be at some risk of developing illnesses which are related to their age.
Experiencing problems that we are able to prevent	Some people become ill or develop conditions and need support to prevent things from getting worse. Sometimes we can use a range of services and work with other organisations to make sure we effectively co-ordinate care and support. This would include supporting carers and families.
Needs help or treatment	People may need extra help (for example, if they experience something like a fall or a stroke), or if their circumstances change, such as if their carer becomes ill. If may be appropriate to take them to hospital, but services should also include other options, such as quickly providing care services in their home.
Ready or preparing to go home	This is support for people who have received help or treatment in hospital and they are ready to go home or need more care, support or treatment to recover. Carers would also need support and training to help the patient recover.
Needs long-term support	People need ongoing care for a long time, or possibly the rest of their lives. This may include the main problems that affect older people such as falls, stroke, chronic obstructive pulmonary disease (bronchitis and emphysema), dementia and other complicated needs. It is very important that carers are involved, and services to support carers are vital.
Mental-health problems in old age	People may have mental-health problems as they get older (for example, dementia and depression).

> I receive excellent care from my local practice



> **Provision for blood pressure monitoring and cholesterol level checks would help improve life**

◀ *Continued from page 8*

Fit and well and growing older

- We published the Time of Our Lives Strategy in 2008. This is our three-year plan (2008 to 2011) to improve and promote the quality of life for people in East Sussex in the later stages of their life.
- We set up the Joint Strategic Needs Assessment (JSNA) Board and agreed a programme to deliver a series of reports which will help us understand wider trends in health and well-being across East Sussex.
- We printed and made available 25,000 copies of 'Forward from 50 – a guide to later life in East Sussex'. This free handbook is packed full of handy tips and instructions on where to get information, which will be helpful as people prepare for life after 50. Due to its success, we printed an extra 15,000 copies and plan to update it regularly.
- We have agreed how day time services will need to be in the future to provide adults and their carers with the right choices. This is summarised in a report called 'From day care to day opportunities'. We reviewed our day time services for older people and we are now planning how to improve them. We have also tested a service to provide day time opportunities for older people from black and ethnic-minority groups.
- We used the £3.2 million of funding we were given from the Department of Health in 2006 for the 'Partnerships for Older People Projects' programme to provide a range of services. Through the programme we have learnt more about what works best and we will use this information to make decisions about our investments in services in the future.
- We have now committed to long-term investment in a range of services including:
  - the Navigator Service, where staff visit older people in their homes, tell them about local services and provide grants for exercise and activities, carers, transport and handyperson services (where someone comes and carries out small jobs for you);
  - improved access to simple aids and equipment which help people stay living at home (such as grab rails which help people get in and out of the bath); and
  - the County Connect Service, which helps staff from a number of partner agencies who work with older people to make it easier to refer people to each other.
- As part of the local area agreement, we have achieved more than our 2008/2009 targets to increase the number of people receiving a range of services which help them to live at home independently.

Next steps

We will:

- continue our work with older people through the Older People's Forums, responding to what is important to their quality of life;
- use the information from the new joint strategic needs assessment reports to make sure we are using current information about future needs to plan our services over the next 10 to 15 years; and

- continue to work with all our partners to provide, develop and assess a wide range of advice and simple services that promote people's health and well-being and support their independence.

Experiencing problems that we are able to prevent

- Health-care staff and social-care staff have worked together to examine how patients are treated. We have put in place a new service which provides community matrons to help all patients with a range of complicated needs to get access to a standard service of care from health, social-care and other support agencies.
- The Joint Information Access Project has finished its review of information available for older people, their carers and staff, and they will now develop better information which will be available in a range of different ways.
- We have been developing the East Sussex Stroke Strategy with help from older people and their carers. This is a plan to bring together a range of services which will help you recover if you have had a stroke. It will also help your carer.
- The telecare service has been running for two years and now has over 2000 users. Some of the most popular telecare equipment includes the bogus-caller pendants, bed-occupancy sensors, pull cords (which are linked to a 24-hour call centre and you can use to call for help) and carbon-monoxide detectors. Telecare is all about giving people peace of mind. If there is a problem at home, your call will automatically go through to our 24-hour monitoring centre and they will arrange help and support for you.
- We introduced the single assessment process (an assessment process that is used across all health and social-care services) in various hospital sites, and we tested this with some GPs. We also set up a new system of providing

people with a folder of all their assessments and service records.
- We set up falls services across the whole county. These are teams of professionals (including occupational therapists and physiotherapists) who provide advice and treatment to older people who are at risk of falling.
- We agreed to develop a new joint commissioning strategy to improve our services for people with disabilities, sight or hearing problems or long-term conditions.

Next steps

We will:

- develop the Improving Life Chances Strategy for people with long-term conditions, physical disabilities or sight or hearing problems;
- continue to improve the ways Adult Social Care and the National Health Service (NHS) work together; and
- improve services for people with particular long-term conditions.

Needs help or treatment

- We held an urgent care workshop with all organisations, patients, the public and carers to discuss with them the work we had done so far and to find out what else we should be doing. We then used this information to plan our future work.
- We agreed an escalation policy. This is a plan about how the PCTs, hospitals and Adult Social Care will work together to make sure they take the right action and have services in place when there is an increased demand on hospital beds, as well as preventing people from going into hospital unnecessarily.
- The single telephone access number (STAN) has worked successfully. This service provides advice to GPs on other services in the community for their patients, so that patients do not have to go into hospital. We are now in the process of rearranging the service, as the current contract ends soon.
- We have developed an Intermediate Care Strategy. This is a plan to bring together a way of developing a range of short-term intensive services which will help prevent people having to go into hospital and help people recover after they have been in hospital.
- GPs are now working in the accident and emergency departments in hospitals in Eastbourne and Hastings to treat patients who may not need go into hospital.
- We introduced emergency-care practitioners. These are clinically trained paramedics who visit people at home as part of the ambulance service. They are able to diagnose people's health issues and provide treatment, if appropriate, at home.
- We introduced an Enhanced Response Team. This is a quick-responding home-care service for people who go to accident and emergency departments and who do not need to go into hospital, but need care and support so they can go home.
- We have produced a draft of the East Sussex Falls and Bone Health Strategy, which we put together when we were taking part in a national audit of falls and bone health.
- We introduced the Generic Worker Rapid Response Team. This is a quick-responding health-care service

for people who go to accident and emergency departments and who do not need to go into hospital, but need health care so they can go home. GPs also refer people to the service.

Next steps

We will:

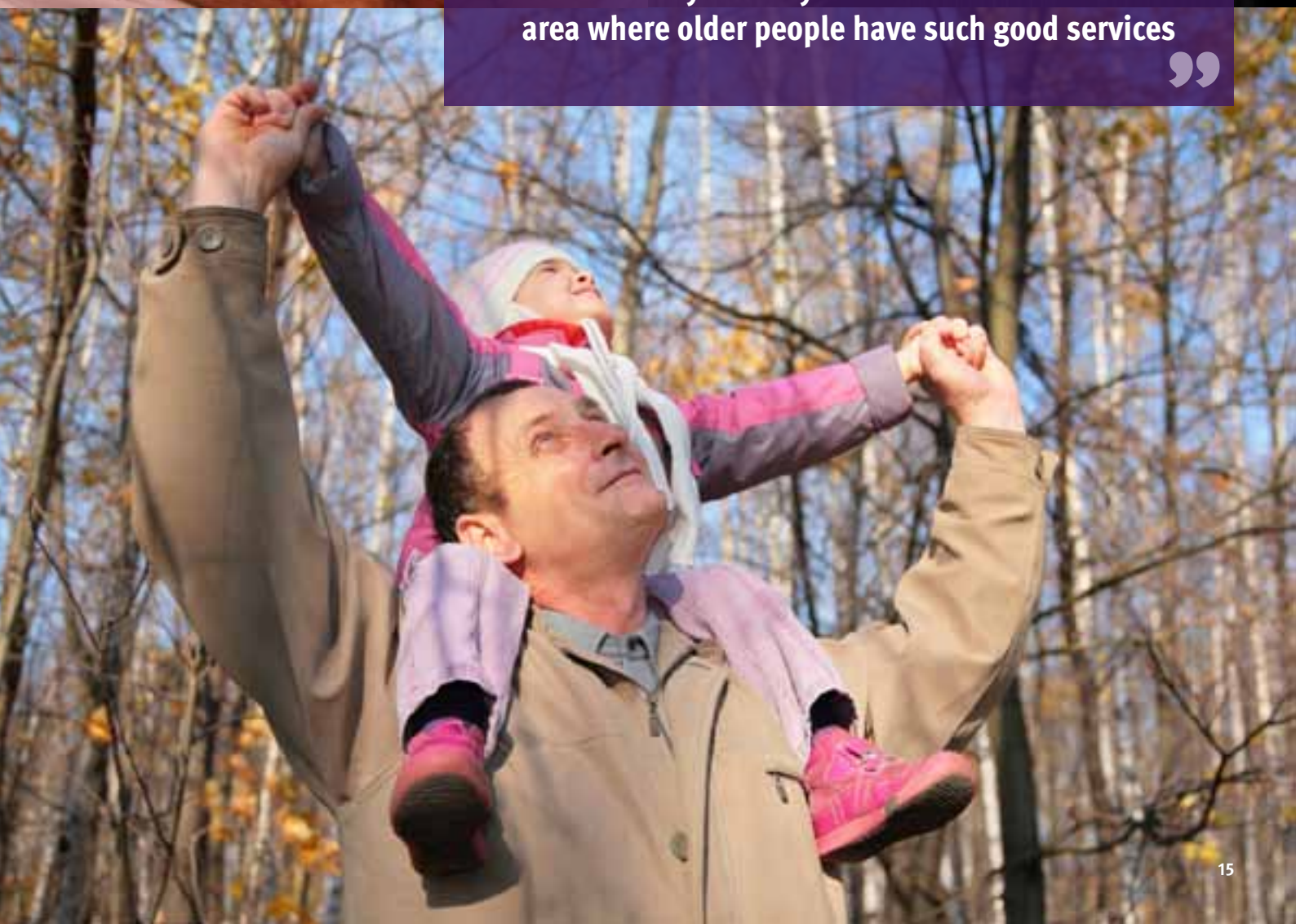
- reduce the number of people who go to accident and emergency at the hospitals in Hastings and Eastbourne by providing other local health and care services;
- provide training and support for staff in residential homes and nursing homes in East Sussex to reduce the number of people going into hospital;
- improve access to a range of short-term intensive services (such as community beds) for people who do not have to go into hospital; and
- reduce the time that people have to stay in hospital by continuing to improve the way health-care and social-care services work together.

Ready or preparing to go home

This is support for people who have received help or treatment in hospital and are ready to go home or need more care, support or treatment to recover.

- We continue to reduce the number of people who are kept in hospital unnecessarily because there was a delay in arranging services to help them go home. This has reduced from more than 60 a week in 2005/2006 to rarely more than 40 during 2008/2009 in general hospitals, and from 30 to less than 10 in mental-health hospital wards.
- We have reviewed the working practices of the team providing services in a specialist ward for older people in Eastbourne Hospital to improve services for patients.
- The hospitals, PCTs and Adult Social Care have agreed a 'Choice Policy', which provides information on how patients can make choices if they are not able to go home, and how staff can support this process.
- We have finished work on improving information available to patients on what may happen and on the choices on a range of other services available when they are ready to leave hospital. This is called the 'discharge information booklet'.
- We have developed a 'carer's pathway', which is to support staff within the hospital to identify carers and make sure those carers have an assessment. This will make sure that carers are supported and included in the planning process when someone leaves hospital. We then set up a working group which focuses on the needs of carers of patients within East Sussex Hospitals Trust.
- We have tested a 'Complex Discharge Training Programme'. This provided focused training sessions to a wide range of staff from all organisations. It gave us information on a range of services, structures and policies that could help staff support their patients when they are ready to leave hospital. We assessed the programme and are putting in place an action plan to introduce this training more widely.
- We have improved access for patients so that they can see social-care assessors when they need to.

> **I consider myself very fortunate to live in this area where older people have such good services**



> **Excellent services from my local GP and quick return of medications by my local pharmacy**

- We have improved our work with adults' and older people's mental-health services – for example, we have developed information packs for patients.
- We have agreed three-year funding for the 'Home from Hospital' and 'Take Home and Settle' services. These services are provided by Age Concern and support people after they have left hospital by providing transport home and help with light housework and shopping.

Next steps

We will:

- aim to improve referral processes between teams to make sure that patients are not delayed in hospital while they are waiting for assessments;
- as early as possible, carry out work and training on planning processes for when a patient leaves hospital; and
- promote best practice with discharges seven days a week.

Needs long-term support

- We have reviewed the way we provide services in our three extra-care housing schemes. Extra-care housing is a special housing scheme for older people which provides 24-hour care and support services to people living in the scheme. We made some changes to make sure that the most vulnerable people (those who have complicated needs or need personal care services) live in the schemes. We also funded an outreach support service to help people to continue to live independently in the community.
- We have successfully developed a new extra-care scheme called Downlands in Peacehaven, which will provide 41 homes, including 11 homes to buy and eight homes for people with dementia. The scheme will open in September 2009.
- We have worked with our partners, older people and carers to develop our plan on how we should use the 'Supporting People' grant in the future. Supporting People pays for housing-related support services that help people live independently. We will consult on the plan from June 2009 to September 2009.
- We are in the process of identifying possible providers for the Age Well project, which will provide a range of care services on four sites in East Sussex. This project will provide 180 beds which will meet the needs of people with dementia and provide intermediate care and respite services (short-term services which provides support for someone either in their home or in residential care, so that their carer can take a break).
- In June 2008 we produced a plan on care services that we will provide at the end of people's lives – health-care and social-care partners have agreed that we will improve the way we deliver services by working more closely with each and with older people and carers.
- We have made three successful bids to the Department of Health to get funding for two years of work. These are working with GP surgeries to support carers, to provide flexible respite for carers of people with dementia, and a support and advice service for people with dementia.
- We held a workshop with over 50 representatives from organisations and with older people, the public and

carers to discuss the work we have done so far and to find out what else we should be doing. We will use their views in our current and future work.

Next steps

We will:

- discuss what housing-related support services are needed to support as many older people as possible, no matter what type of housing they live in;
- review our strategy to improve and deliver services for carers;
- introduce a co-ordinated range of services to support people at the end of their lives; and
- develop and improve the range of day-care services and activities across the county.

Mental-health problems in old age

- We completed a specification (this is a description of the services we would expect to be delivered to meet people's needs) for a specialist dementia home-care service and we will start work to find interest from possible service providers in 2009. We hope to introduce services in 2010.
- We successfully reviewed how patient mental-health services are used, so we can make sure they more effectively meet the needs of older people. We made changes without disrupting the patients.
- The above review helped us to use funding to:
  - continue to have services provided by the Memory Assessment and Support Team (a service for people with early signs of memory loss) and the Intensive Community Support Service, whose funding was about to end; and
  - start discussions on how to improve access to intermediate-care services for older people with mental-health problems. These are a range of services which people receive between hospital and home and which help prevent them having to go into hospital or allow them to leave hospital early.
- We carried out work to prepare for the publication of the first National Dementia Strategy. We paid for an independent consultant to tell us what work we needed to do to make sure we dealt with local services, future development plans and the expectations of the national strategy.
- We are currently developing a number of schemes to provide more specialist accommodation for older people with mental-health needs. These include the Downlands extra-care scheme and the Age Well project.

Next steps

We will:

- as early as possible, identify any signs of mental-health issues which older people in primary care show;
- provide more services from the Memory Assessment and Support Teams;
- work with our partners to make sure people leaving hospital are able to get back into the community as easily and smoothly as possible; and
- introduce intermediate-care plans to reduce the time people have to stay in hospital, and help them back into their communities.

Your views

We welcome your views, comments, ideas and suggestions on our strategy and plans. They will help us to make any changes to our plans as we put them into action.

For more information, or to let us know what you think about this plan, please contact:

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You can get a full copy of this strategy and other plans or information we have discussed, such as the 'The Time of Our Lives Strategy', 'Forward from 50 – a guide to later life in East Sussex' or the Choice Policy, by phoning our Strategic Commissioning Team on 01273 482533 or by emailing policystrategyadmin@eastsussex.gov.uk.

Getting more copies of this leaflet
You can get all our leaflets in large print, easy read format, in Braille, on audio tape or CD, or in other languages. Please phone Social Care Direct on 0345 60 80 191 (calls may be recorded). They are also available in PDF form, which you can download from our website at eastsussex.gov.uk

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