Agenda Item 9

Report to:	**East Sussex Health and Wellbeing Board**
Date:	**13 February 2014**
By:	**Director of Adult Social Care and Health, East Sussex County Council**
Title of Report:	**Joint working between the Clinical Commissioning Groups (CCGs) in East Sussex and East Sussex County Council (ESCC)**
Purpose of Report:	**To provide the Health and Wellbeing Board with proposals for joint working between the CCGs in East Sussex and ESCC and for the deployment of the Better Care Fund**

RECOMMENDATIONS:

The Health and Wellbeing Board is recommended to:

1. **agree proposals, as set out in the report, for joint working between CCGs in East Sussex and ESCC which commits each organisation to work in partnership to develop a clinically and financially sustainable local health and social care system;**
2. **agree the proposals set out in the report for the use of the Better Care Fund; and**
3. **agree to receive a further report if there are any significant changes to the Better Care Fund proposals through the NHS assurance process.**

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1. Financial Appraisal

1.1 The total health and social care spend in East Sussex is approximately £1b. Responsibility for commissioning sits with three CCGs, the NHS Area Team and East Sussex County Council. The key providers of services are NHS Trusts, the County Council and the private, voluntary and community sectors. The majority of health services are delivered by NHS Trusts and social care services through external providers. East Sussex faces significant challenges through increased demand for support caused by demographic changes, major reductions in local authority funding and the need to establish clinically and financially sustainable health care, which will require a shift in investment from acute to community and primary care services.

1.2 The Government has introduced the Better Care Fund (BCF) with a significant element coming into effect in April 2014, and full implementation by April 2015. The purpose of the BCF (formerly known as the Integrated Transformation Fund) is to achieve greater levels of integration across health and social care to improve outcomes, shift investment from acute to community and primary care and deliver greater efficiency and value for money. Details about the BCF are attached at **Appendix 1.** Although this is a new fund, the money is drawn primarily from existing NHS funding streams. Locally the BCF revenue allocation will rise to £36.551m in 2015/16 from a total national allocation of £3.8b. This does, however, include £2.155m new money to "accelerate transformation" to integrated community and primary based care. The fund also includes £9.25m which was previously the NHS transfer to social care and which is already included in the Adult Social Care medium term financial plan. Current proposals, which are set out in the required templates, are attached at **Appendix 2 and 3.**

1.3 The release of approximately half of the BCF funding in 2015/16 will be dependent on meeting agreed performance targets in 2014/15, with some set nationally and some locally. The national targets will include areas of longstanding challenge, such as emergency admissions to hospital, which will present a significant risk that not all of the BCF monies will be released in East Sussex.

2. Background and Supporting Information

2.1 There is a very strong local and national evidence base that integrated care improves outcomes for the population and increases patient and client satisfaction. The evidence that integrated working delivers overall savings is much less clear. There has been a strong local commitment to increasing integration and a range of joint health and social care commissioning strategies have been developed. Alongside integrated joint commissioning we have a wide range of integrated services and initiatives, including the

Joint Community Re-ablement Service, Integrated Community Equipment and Neighbourhood Support Teams.

2.2 Although there is a commitment across all health and social care partners to use the BCF to support integration, there is a more significant recognition by all partners that the scale of the challenge faced in East Sussex requires a broader level of transformation to deliver a clinically and financially sustainable health and social system. These challenges include a significant reduction in local government funding, budget deficits and constraints in the health economy and the need to shift health investment from acute to community and primary care. The local health and social care system will need to initiate an urgent and fundamental review focussed on the needs of the whole population, evidence of best practice and the totality of available resources across health and social care. The review, which will include full engagement with East Sussex residents, will determine how resources should be deployed to achieve the best possible outcomes for local people. This will enable consideration of the best models of care and organisational arrangements to meet health and social care need now and in the future.

2.3 It is proposed that an agreement is reached on how transformation will be managed through a formal programme entitled East Sussex Better Together, involving all of the East Sussex CCGs and ESCC. This programme will ensure a common approach within East Sussex but will lead to the development of services which reflect the individual characteristics of each CCG area and the requirements of their respective Boards.

2.4 The proposals for the BCF seek to promote integration and the transformation of health and social care services across the whole of East Sussex. The proposed plan builds on the work already being undertaken and agreed through joint commissioning strategies but also takes account of the need for flexibility for 2015/16 and beyond, when a broader more radical approach will be put in place through the East Sussex Better Together. **Appendix 2, Annex C** provides a more detailed description, which will be included in the BCF submission, of how transformation will be managed within East Sussex.

2.5 It should be noted that the BCF includes an element of Disabled Facilities Grant capital funding from 2015/16, which is currently contained within Borough and District Council budgets. This funding is already deployed in an area of support that is critical in enabling vulnerable people with complex needs to live independently within their own homes. It is not the intention to redirect this investment as it will have an adverse impact on the whole system of support for East Sussex residents. This is also now acknowledged in the latest guidance which emphasises passing this allocation to Borough and District Councils in a timely manner.

2.6 Although the focus of the BCF is on adult health and social care services it is essential that the benefits of integrated working also include children's services and children's mental health services across East Sussex.

3. Conclusion and Reason for Recommendations

3.1 The proposals outlined in this report set out an approach to working across health and social care which is transformational and requires closer partnership and joint management of significant programmes of change. There will be risks attached to delivery of the programme and these will be managed through core CCG and ESCC processes. Given the scale of the challenges we face in East Sussex and the interdependence of health and social care a partnership approach is the most effective way of delivering the transformation required whilst meeting Government expectations on integration and performance across the whole health and social care system.

3.2 The BCF proposals set out in the report will enable the ongoing transformation of health and social care in East Sussex and the development of more integrated services. It is important to note however that the plans for 2015/16 and beyond are likely to see a more radical approach based on the specific challenges faced in each area within East Sussex and the work to be undertaken in partnership.

3.3 The BCF proposals have been agreed by each East Sussex CCG and ESCC. There is however an assurance process requiring agreement from the NHS Area Team with potential further oversight by the Department of Health. If, as a result, there are any significant changes to the BCF a further report will be made to the Health and Wellbeing Board.

Keith Hinkley, Director of Adult Social Care and Health, East Sussex County Council

Briefing Note: Better Care Fund

Key points

- **Resource to manage better across health and social care but locally this comes with risks**
- **There is only very limited new money across health and social care in East Sussex, which given the CCG deficits creates significant risk**
- **The additional monies are enough to off set the budget cuts to local authorities and most of the funding is drawn from CCG budgets**
- **Social care is still faced with making significant cuts to balance budgets due to other funding reductions**
- **Risk of reduced flexibility due to increased bureaucracy**

Supporting Information

The Chancellor of the Exchequer announced in the Spending Review Statement on 26 June 2013 the introduction of a £3.8bn pooled budget for health and social care services from 2015/16, now known as the "Better Care Fund". This funding is to be shared between the NHS and local authorities to deliver better outcomes and greater efficiencies from more integrated services for older and disabled people.

The £3.8bn is made up of:

- £900m Existing "Health funding for Social Care". This is not new money. ASC's budget assumes funding of **£9.254m** in 2013/14 – this allocation will be required on an ongoing basis to meet core service activities.
- **£200m** **Additional allocation** from 2014/15 to "accelerate transformation" – East Sussex allocation is **£2.155m**. This should be added to the "Health funding for Social Care" mechanism and will need local agreement. Funding will only be paid on a jointly agreed and signed two-year plan for the BCF.
- £300m Existing Reablement funding. Local CCG allocations have been in the region of £3m, for which specific projects and service developments are agreed through Joint Commissioning Board. Funding will be taken from core local CCG budgets; which may result in pressure, depending on current budget construction.
- £100m Existing Carers funding. Local agreement to be reconfirmed to increase CCG investment in Carers to £4m by 2014/15. Local issues may arise depending on budget construction.
- £1.9bn Described as an additional funding this is drawn from CCG budgets:
  - £1bn for pressures, demography and one-off costs of care and support reform
  - £1bn for driving forward integration. To be spent on Adult Social Care activity that alleviates health pressures. This element of funding is not automatic but dependent on showing commitment to integration and taking action.

  - Funding will be allocated out of CCG budgets and given the deficits in the health systems may lead to cuts elsewhere that will undermine healthcare. Estimated local budget increases of 2.3%. Local pressures, particularly with contractual arrangements with the Hospitals Trust, will impact on how transfer is managed.

- £400m Capital Grants, including £220m Disabled Facilities Grant administered by district/borough councils, transferred from DoH and other Government Departments. Not new funding as bringing existing resources together.

The 2015/16 CCG revenue allocations for transfer to the Better Care Fund are:

Eastbourne, Hailsham and Seaford CCG	£12.749m
Hastings and Rother CCG	£13.188m
High Weald Lewes Havens CCG	£10.614m
Total	**£36.551m**

The BCF funding from 2015/16 will be put into pooled budgets as part of Section 75 joint governance arrangements between CCGs and Council, with plans for spending the funds needing to be jointly agreed. Although this represents a shift in how decisions are made about investment this funding will be drawn primarily from CCG budgets. Taking this into account there will still be a significant reduction in resources across health and social care in East Sussex as a consequence of reductions in local authority budgets.

Plans will need to satisfy nationally prescribed conditions including:

- Protection for social care services
- seven day working for social care to support patient discharge and prevent unnecessary weekend admissions
- Improved data sharing between health and social care
- Reducing A&E attendances and emergency admissions

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**East Sussex County Council**
Clinical Commissioning Groups	**NHS Eastbourne, Hailsham and Seaford CCG**
	NHS Hastings and Rother CCG
	NHS High Weald, Lewes, Havens CCG
Boundary Differences	**The local authority and CCGs boundaries are fully aligned**
Date agreed at Health and Well-Being Board:	**13/02/2014**
Date submitted:	**14/02/14**
Minimum required value of ITF pooled budget: 2014/15	**£11,378**
2015/16	**£41,098**
Total agreed value of pooled budget: 2014/15	**£TBD**
2015/16	**£TBD**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**NHS Eastbourne, Hailsham and Seaford CCG**
By	Amanda Philpott
Position	Joint Chief Officer EHS CCG and H&R CCG
Date	<date>

Signed on behalf of the Clinical Commissioning Group	**NHS Hastings and Rother CCG**
By	Amanda Philpott

Position	Joint Chief Officer EHS CCG and H&R CCG
Date	<date>

Signed on behalf of the Clinical Commissioning Group	**NHS High Weald, Lewes, Havens CCG**
By	Frank Sims
Position	Chief Officer HWLH CCG
Date	<date>

Signed on behalf of the Council	**East Sussex County Council**
By	Keith Hinkley
Position	Director of Adult Social Care and Health
Date	<date>

Signed on behalf of the Health and Wellbeing Board	East Sussex Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Glazier
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This draft plan has been produced by East Sussex CCGs and East Sussex County Council, although reflects a number of existing programmes in which our health and social care providers are active participants

Limited consultation will be possible on the draft plan, prior to final submission on 4 April 2014. The narrative that sits alongside this BCF plan aligns well to the work programmes already in place as part of our integrated care and urgent care networks, of which providers are members, as well as provider specific engagement activity related to 2014/15 commissioning intentions. Our Providers will also have an opportunity to review the draft plan as part of ongoing discussions at our Partnership Boards.

We recognise that going forward we need to carry out detailed service redesign and contingency planning in partnership with our providers. Leaders from all of the NHS organisations in East Sussex and Social Services and Healthwatch have been meeting to develop East Sussex "2020 Vision" in EHS and H&R CCGs and discuss the best way to take this transformation programme forward. HWLH CCG is also developing its vision through the development of "The Green Triangle", working with neighbouring CCGs and providers outside East Sussex.

We will establish strong governance arrangements that will ensure East Sussex Healthcare Trust, Sussex Partnership Foundation Trust, Brighton and Sussex University Hospital NHS Trust, and

Maidstone and Tunbridge Wells NHS Trust are involved in service redesign discussions and planning from an early stage. We will also strengthen engagement with social care and voluntary/private sector providers. We see this as an iterative process which also needs to be embedded into the commissioning cycle.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The development of the BCF provides a significant opportunity to meet the priorities identified by our communities. A shift to community based services, with better integration and coordination between organisations is a strong theme coming out of each of the CCGs public and patient events, as well as local authority led engagement events. Clients, carers and the public have asked us to change the way we deliver services for people with long term conditions, particularly for clients who have complex medical and mental health issues. Participants at these events identified that better integration of resources and holistic health and social care assessment would deliver "better communication, better confidence, better experience, more efficient, prevents complications, risks to patients if less people"[1]. The priorities and changes identified at the 2013 *Shaping Health Services* events strongly align to the National Voices narrative for person centred care. We will use the outcome driven statements like those in the BCF narrative to guide development of services and to identifying what success would look like for the people that use our services. This also builds on East Sussex's application for Integration Pioneer status, where our focus on client and carer experience of services was particularly noted. We will maximise the opportunity to share and discuss plans with clients and carers through existing partnership forums before the BCF plan is submitted to NHS England. Throughout 2014/15 we will engage with clients and carers through the developing governance structure overseeing the detailed service redesign. We will also continue to engage through Healthwatch who sit on the Health and Wellbeing Board.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Integration Pioneer bid	East Sussex expression of interest – see Annex A
East Sussex JSNA	http://www.eastsussexjsna.org.uk/
East Sussex JHWS	See Annex B
East Sussex Narrative to support Better Care Fund plans	See Annex C

[1] H&R CCG Shaping Health Services Event 27.06.13 – Event Report

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our vision is to create a health and social care system that promotes health and wellbeing, prevents ill health and improves the outcomes and experience of our population. This will be delivered through a focus on population needs, better prevention, self care, improved detection, early intervention and proactive, joined up response to people that require care and support across traditional organisational and geographical boundaries.

We also want to maximise the value we get from the health and social care investment, building capacity in our communities, primary care, community health care, social care, the voluntary sector and other providers to enable people to keep as mentally and physically healthy and independent for as long as possible.

Where appropriate and practical we will make additional investment in primary care and community based services that will deliver real alternatives to acute hospital based care, meaning that only care that has to be provided in an acute hospital setting will be delivered there. This will move care and support away from acute hospitals and institutional care settings to the local community and homes where people live.

When a person does need acute hospital care, we will ensure that not only can they access safe high quality care but they are then discharged in a timely and planned manner to continue to live as independently as possible at home.

Promoting good mental health, including taking preventative actions and providing support early on is a priority, to improve the wellbeing, quality of life and health of those living with and recovering from mental illness.

We will achieve this vision by:

- Reviewing how health and social care resources are currently used to ensure we are maximising the use of public money to meet the needs of our population
- Jointly developing commissioning priorities across primary, community health, social care and the secondary care, to design an integrated health and care system at a locality level to deliver the outcomes required for clients and carers.
- Understanding and tackling health inequalities, ensuring we meet the diverse requirements of our population, and taking into account the different needs of rural and urban localities and those client flows to acute settings of care outside of East Sussex.
- Providing person centred care, enabling clients and carers to be partners in the design

and delivery of their own care, with the back up of professional expertise and support where needed. Clients will be actively involved in making choices about improving their health and well being through self management, involvement in care planning and use of personal budgets. Understanding and addressing the needs of carers in service provision is seen as a key priority, particularly given the demographic challenges in East Sussex.

What will be different

- Improved client and carer information and education to support decision making and self management
- Improved, coordinated access into primary care, community health and social care services
- Integrated front line delivery and processes to provide joined up care 7 days a week, particularly where it prevents inappropriate admission to hospital and residential/nursing care
- Strengthened locality working, with services designed to reflect local demand and need and delivered as close to home as possible
- Integrated strategies to shift resources from acute or institutional care to community based settings so that planned and unplanned care is delivered in the right place at the right time

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aims and Objective

1) Changing the setting and model of care

In the future clients will be able to receive their care in a variety of settings based on clinical priorities and what delivers the best outcomes. Where possible, care will be provided at home, or close to home, with clients accessing appropriate care in settings outside of the traditional acute hospital settings. This change to out of hospital care will require investment in alternative service models, with more resource being used to provide care at home, in GP surgeries, in other local facilities and outpatient clinics.

2) Improving Primary Care

Primary Care is central to transforming the care and support clients receive in the community. If primary care is to truly coordinate and transform care, primary care itself must be transformed to ensure it is fit for the future and meets clients' needs. East Sussex's CCGs, working with NHS England, will continue to develop strategies to achieve this transformation.

Improving access to primary care, and delivering a wider range of services in a flexible way, will make primary care the setting for many services rather than hospitals. This will require improved access at weekends and later into the evenings to provide 7 day care that is more convenient and responsive to the needs of the population. The changes and improvements are not just limited to General Practice, as Pharmacy, Ophthalmology and Dentistry are also key to preventative and proactive care.

GPs, working in a multidisciplinary way with health and social care professionals and the third sector are a focal element of delivering integrated and proactive care for people at greatest risk of becoming ill or needing intensive support.

3) **Supporting Older People and those with Long Term Conditions, including people with mental health needs**

The long term conditions model needs to focus on pro-active management to meet people's care and support needs; promoting and enabling self care, improving access and choice through more convenient and planned options for care, and making services more cohesive so that care is better co-ordinated and the system of care is less complex.

Transforming the way the system works will help prepare people with the correct information and connect them with the right advice or treatment, at the right time and in the right place. Developing and extending care closer to home and providing more support to people to navigate the system will also relieve pressure on emergency services, allowing them to concentrate on treating those with the appropriate highest level of need.

How we will measure these aims and objectives

These aims align to a number of priorities in our Health and Wellbeing Strategy Action Plan, and where relevant will be monitored against existing measures that are overseen by the Health and Wellbeing Board. They also align to the performance and financial metrics in our BCF plan.
As we develop the details of our integration plan programme we will also develop the measures of success. We will work with clients, carers and providers to set outcome and performance measures so that we can evaluate our progress over the next 2 years.

What measures of health gain will you apply to your population

We would look to measure health gain in two key areas that improved coordination of integrated care should improve:

a) Readmission rates, particularly for those who are vulnerable or with Long Term Conditions
b) The quality of life experienced by those in need of health and social care services.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery

- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Our 2014/15 commissioning intentions and existing primary care, integrated care and urgent care work programmes show our commitment to enable people to live as independently as possible and in the most appropriate place according to their needs. We are already working on a range of work programmes as outlined in the BCF narrative, but we need to increase the scale and pace of change. We will review and build on what we are already doing to ensure what we deliver is bolder and more integrated.

The East Sussex 2020 Vision includes five key system objectives:

1. Increased preventative care and promotion of health and wellbeing
2. Multi-discplinary health, social care, vol. sector and community working
3. Improved outcomes for clients/ population
4. Improved client experience
5. Financially sustainability for the whole system

The schemes that will be implemented to achieve the objectives are outlined below

Scheme/area for development	
Using business intelligence and risk profiling to understand needs	
Pro-active care and Care planning	
Older people and people with LTCs empowered to self-manage	
Integrated health and social care locality teams	
Shifting planned activity from secondary care into the community	
Faster access to specialist assessment and diagnostics	
Procedures in an outpatient setting rather than as a day case	
Improved access to primary care and locally-focused diverse provision based on local need	
Increased access to rapid support in people's own homes and supported decision-making about people with urgent care needs	
Use of A&E for urgent care needs only when can't be dealt with by other services	
Support for people who need bed-based care	
Minimising time spent in hospital by improving discharge	

The schemes and priorities for the BCF align well to the needs identified in our JSNA and the JHWS. The BCF plans and detailed programme plans will be developed collaboratively with the Local Authority and 3 CCGs. This will ensure that our health and care system is designed to take into account the flow of clients into the different acute providers utilised by our population.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The scale of the investment required into the BCF by health and social care can not be delivered without service transformation. The establishment of the full BCF in 2015/16 will require agreement on the areas of investment, including approximately £20m that is currently invested in acute services by the 3 CCGs. A fuller assessment of the impact on providers will be carried out as plans are developed in detail to identify and reach agreement on the scale of change required

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Integrated Governance

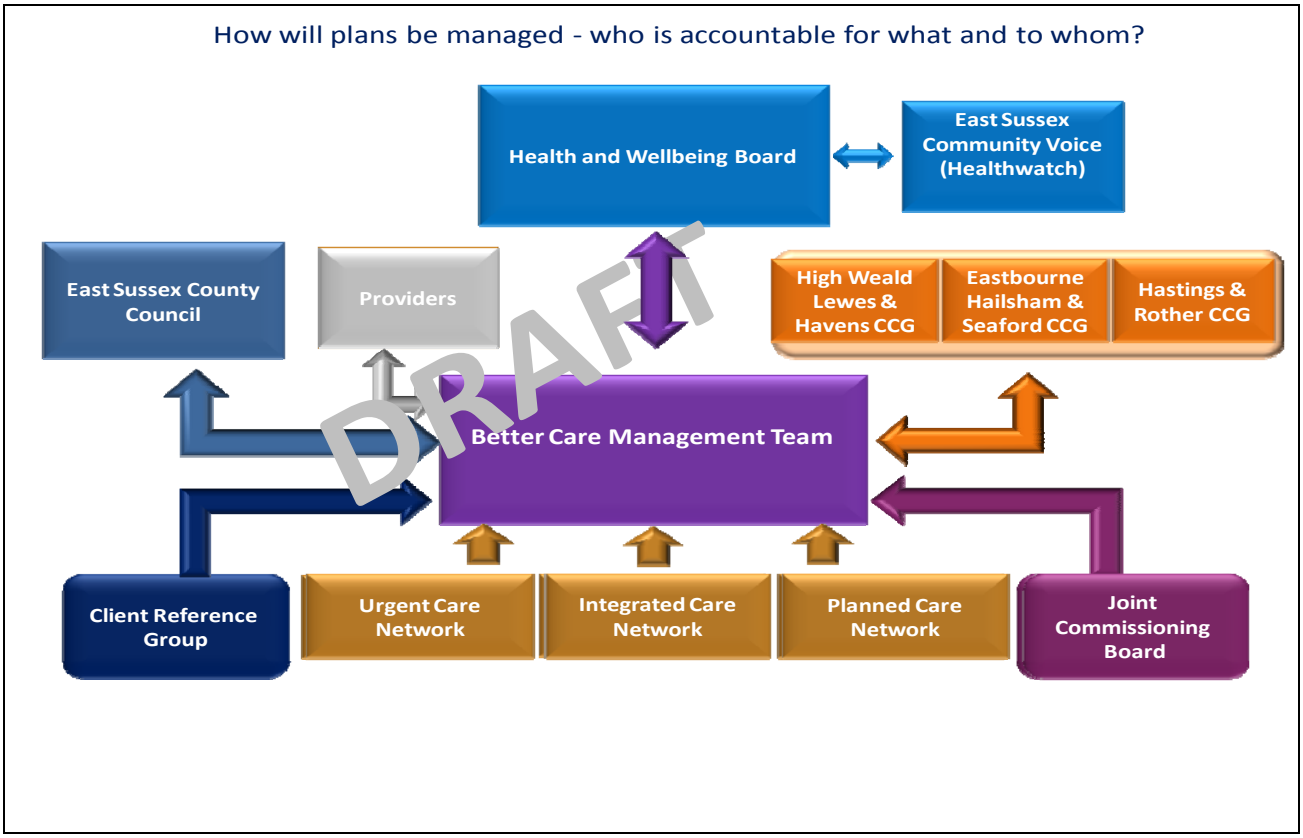
Our complex system, and the challenges individual organisations face, requires better partnership arrangements than ever before. Leaders from all of the NHS organisations in East Sussex and Adult Social Care, and Healthwatch have come together to discuss the best way to take forward the transformation required as part of realising East Sussex 2020 Vision and The Green Triangle.

As partners we will need to work collectively for the whole system to create, agree and implement a clear and credible plan for a sustainable system of health and social care to secure the best possible outcomes for East Sussex residents, over and above immediate organisation interests.

Good governance between East Sussex organisations will provide the direction and leadership for the system, assurance that BCF programmes are working together to deliver the overall strategic objectives and that risks have been identified and managed.

We will look to develop our governance arrangements in line with the diagram below:

Potential East Sussex Governance structures:



3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Protecting social care services in East Sussex means continuing to ensure adults who are at risk of harm, abuse or neglect are safe, and helping people to live independently for as long as possible, through person centred support . We are working hard to make sure that we provide the right support to people who need it, and whilst maintaining eligibility criteria is one element of this, we are also looking at ways of preventing people from needing support in the first place.
Year on year we continue to support people to remain living independently in their own homes, with maximum choice and control over the support they receive. Within the context of growing demand and significant budgetary pressures we want to continue to develop personalised services by approaching them in a more innovative way. We want to help more people to help themselves , as well as focusing on reablement and more proactive support to ensure people remain well, are engaged is self management , and where ever possible are improve people's independence so they can stay within their own home.

Please explain how local social care services will be protected within your plans.

NHS funding for social care has been used in East Sussex to enable the local authority to sustain the current level of eligibility criteria. A commitment remains not to destabilise current investment patterns, whilst the plans are formulated for a major systems transformation in 2015/16 and beyond.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

East Sussex has a good record of investing in community services that deliver "7 day working" in an integrated delivery model. This includes our integrated services such as the Joint Community Rehabilitation Team, Integrated Community Access Point, Integrated Night Service as well as a range of other core services including the District Nursing teams and homecare providers. There is however more that we can do to ensure there is a systematic whole system approach to 7 day service delivery, particularly to support admission avoidance and discharge.

NHS Improvement has identified four levels to assess and plan the delivery of seven day services[2]. This provides a framework for service models to be reviewed against and identify further areas where seven day working will support admission prevention, early diagnosis and intervention and/or early supported discharge. We will work with the Academic Health Sciences Centre Network and our Public Health team to review the evidence base and plan improvements.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health and social care services will use the NHS Number subject to resolution of national information governance issues. The NHS number is regularly matched to Social Care records held on CareFirst.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The NHS Number will be used as the primary identifier across East Sussex. It is expected that this will be in place by April 2016.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to using systems that are based upon Open APIs and Open Standards. As providers implement plans for new information systems eg. System One, we will look to maximise opportunities to improve the interface between systems to support integrated working.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit

[2] Equality for all: delivering safe care- seven days a week

requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

We will review and continue to maintain an information governance framework that ensures we meet all Caldicott requirements. This will meet cover the NHS standard contract requirements and support professional and clinical practise.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

East Sussex has been developing multidisciplinary working, centred around risk stratification of GP Practice populations using Sussex Combined Predictive Mechanism (CPM). Emerging Primary Care strategies envision GPs taking a lead in coordinating care for people at high risk of hospital admission. Further work will be undertaken to define and implement locality models of care, ensuring accountable lead professionals are allocated and care plans are in place for the identified client cohorts.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

The risks outlined below are the high level risks and mitigating actions associated with the East Sussex plans. A more detailed risk management process will be put in place using core NHS and local authority systems

Risk	Risk rating	Mitigating Actions
Schemes do not deliver the planned shift of resources required in the timeframe required to secure funding for 2015/16 and future transformation.	High	Establish robust governance by means of the East Sussex BCF Management team. Detailed business planning throughout 2014/15 to support delivery of BCF plans in 2015/16.
Shifting of resources to fund new integrated care schemes will adversely affect providers, particularly the acute sector	High	The development of our plans for 2014/15 and 15/16 will be set within the context of 2020 Vision and The Green Triangle, allowing for a holistic impact on our providers
The Care Bill will result in significant cost pressure that is not fully quantifiable and will impact on the sustainability of investment plans	High	We will undertake regularly reviews of the potential impact of the Bill on investments and disinvestments as we develop our BCF plans

The BCF plans are not achieved due to providers not being able to mobilise required workforce capacity and capability	High	Development of an integrated workforce plan to be overseen by the East Sussex BCF Management Team
Planned implementation of IT systems by providers (NHS/ASC) do not support integrated working	Medium	Development of an integrated IMT plan to be overseen by the East Sussex BCF Management Team

Pioneers in integrated care and support

East Sussex

Name of local authority or PCT:
East Sussex County Council (ESCC)
Name and position of senior officer(s) at the local authority and/or PCT who has agreed this expression of interest:
Keith Hinkley, Director of Adult Social Care East Sussex County Council
Name and contact details of liaison person (if known) or other contact:
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Names of bidding partners:
East Sussex County Council, East Sussex Clinical Commissioning Groups, East Sussex Healthcare Trust, Sussex Partnership Foundation Trust

1 Introduction

This bid represents a fantastic opportunity for both East Sussex and the Department of Health to build on the excellent progress that we have made in transforming our local economy from that of being an outlier to one that is frequently lauded on its success. We have come a long way on our improvement journey and the fact that we have very unique challenges has made our progress even more remarkable.

East Sussex has one of the highest populations of older people (particularly people aged 85 and over) in the country. It is facing huge financial challenges with a deficit of £60m in the local NHS economy in the current year and a County Council facing a £60m savings programme over the next 3 years. This is compounded by the significant risk posed by the shift of local government funding towards retention of business rates in an economy with a very low platform of business infrastructure. Our geography comprises large rural areas with significant challenges to service delivery in terms of access, staff recruitment and retention. It includes areas of multiple deprivation in coastal towns such as Hastings (one of the top 20 most deprived areas in the UK). We are unique in our area in having an integrated acute and community provider, an NHS provider trust with acute services based on two sites 13 miles apart, and 5 community hospitals. One of our three Clinical Commissioning Group's (CCG) areas flows to an acute service which has 3 cross-boundary providers (in neighbouring Brighton and Hove, Kent and West Sussex).

Against this backdrop, we have undertaken a substantial programme of transformational change centred on integrated working. We have now moved on from a position of being subject to Ministerial scrutiny for having the highest number of delayed transfers of care in the country, high numbers of admissions to residential care, zero stars as an Adult Social Care department, and from negative public perceptions. A programme of work is now underway, driven by our cross agency Integrated Care Network. This programme is making great progress with implementing person centred care with integrated teams, built on joint decision making between health, social care, mental health, and other partner agencies. As a result of our interventions, the number of permanent admissions to residential/nursing care has reduced by over 10%, delayed transfers of care per week have more than halved over a five year period, and in 2012/13 14,466 people received self-directed support. Our newly implemented Joint Community Rehabilitation (JCR) service has shown outstanding success during the first year of integration operation. It has prevented 1000 admissions to hospital, with 96% of clients* satisfied or very satisfied with the service provided.

We can deliver transformational change. But we now need help to do so at the scale and pace required to meet the needs of local people and to deliver the sustainable integrated health and social care system that they have the right to expect. Here we will outline how you can support us in the next critical stage of our journey.

** Note that for the purpose of this document, people who use our services will be referred to as 'clients', preferred naming convention obtained via user consultation*

2 Claims against selection criteria for pioneers

2.1 Articulate a clear vision of its own innovative approaches to integrated care and support

"I am absolutely delighted with the service that was provided for me. To think – I was discharged from hospital at 6pm on a Friday night and one of your staff was here some 15 hours later at 9am on Saturday…

Each member of your staff has been most helpful in the way each has assisted me to get going again, What has particularly please me is the way each worker has treated me as a person. …… Life is here to be continued to the best of my abilities and there has been no comment about age or disability"

This is a quote from one of our clients, and to us, represents what we feel integration is all about. We want every client to experience this level of care and as such are pressing ahead with an ambitious transformation programme to deliver integrated care so that even more people are delighted with the service provided.

Our vision for integrated care in East Sussex

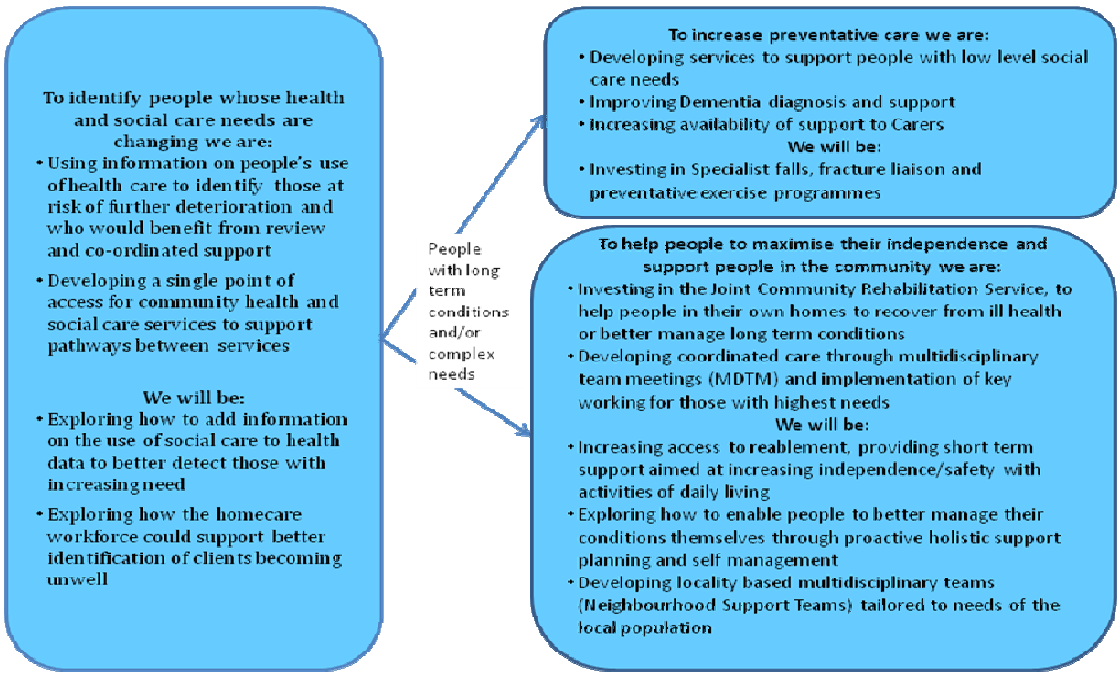
We want to improve the outcomes and experience of clients through a focus on better prevention, detection and joined up response to people with health and social care needs. We also want to maximise the value we get from the health and social care investment and support the shift of resources from acute and institutional care to person centred based care.

What are we currently working on?

We already have agreed approaches to prevention, care co-ordination and urgent needs as part of our integration programme. These are some of our projects underway:

- Development of an operating model for a single access point for health and social care services
- Increasing capacity in the independent homecare sector to provide reabling homecare
- Implementation of models of shared care through multidisciplinary working and care planning
- Development and implementation of community pathways to avoid unnecessary hospital admission
- Optimising the use of current bed based intermediate care capacity and implementing improvements to whole system working
- Reviewing and exploring models of integrated care provision for community health and social care services.

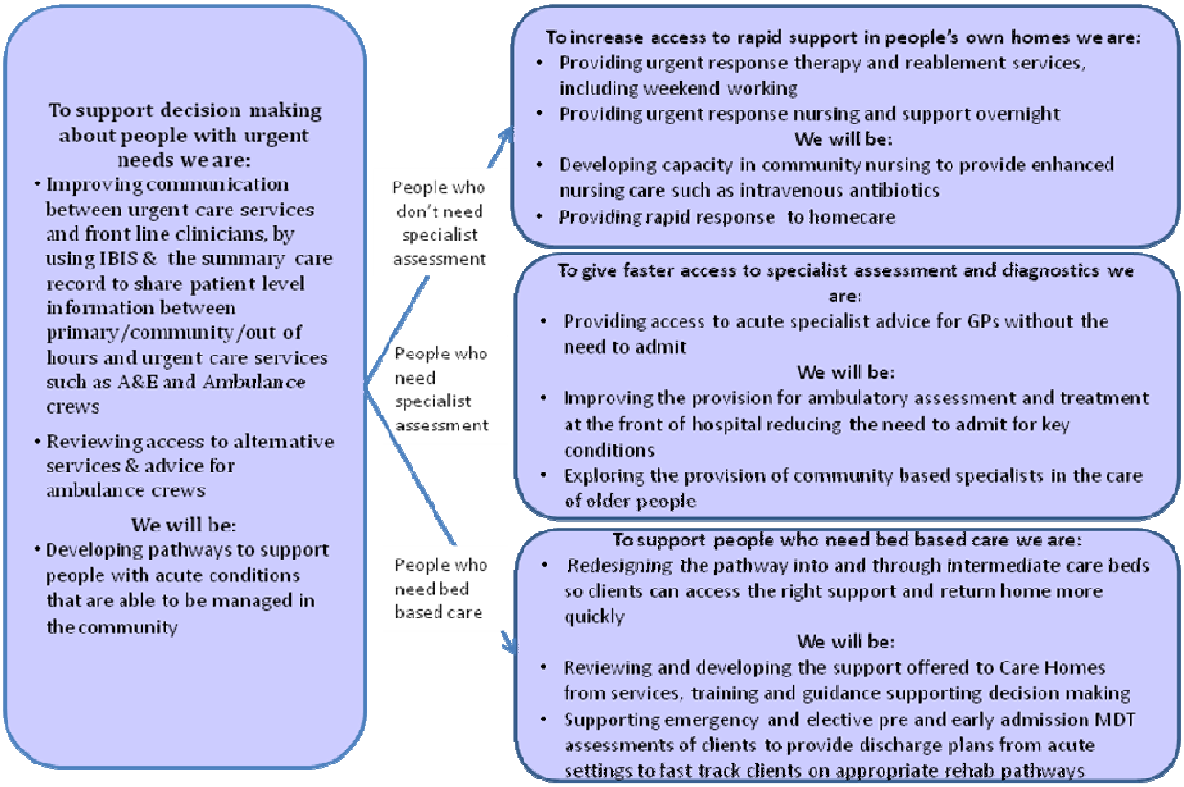
Our integrated approach to preventative and co-ordinated community care



Pioneers in integrated care and support

East Sussex

Our integrated approach to people with urgent needs



What would integrated care look like for our clients?

We have taken into account the narrative for person centred care when identifying what success would look like for the people that use our services. We aim to ensure that the following statements in particular are taken into consideration in the design of our integrated initiatives:

- All my needs as a person are assessed
- My carer/family have their needs recognised and are given support to care for me
- Taken together, my care and support help me live the life I want to the best of my ability
- I work with my team to agree a care and support plan
- I can plan ahead and stay in control in emergencies
- I have systems in place to get help at an early stage to avoid a crisis
- I tell my story once
- The professionals involved with my care talk to each other. We all work as a team
- I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time
- I am aware of all the support available to help me
- I am told about the other services that are available to someone in my circumstances, including support organisations
- When I use a new service, my care plan is known in advance and respected.

At the heart of our vision for integrated care and support are our projects that deliver support for long term conditions. Our long terms conditions initiatives seek to improve outcomes and experience for clients and maximise the use of resources. The focus is on improving the quality and productivity of services for these clients and their carers so they can access higher quality, local, comprehensive community and primary care. This will in turn, slow disease progression and reduce the need for unscheduled acute admissions by supporting people to understand and manage their health.

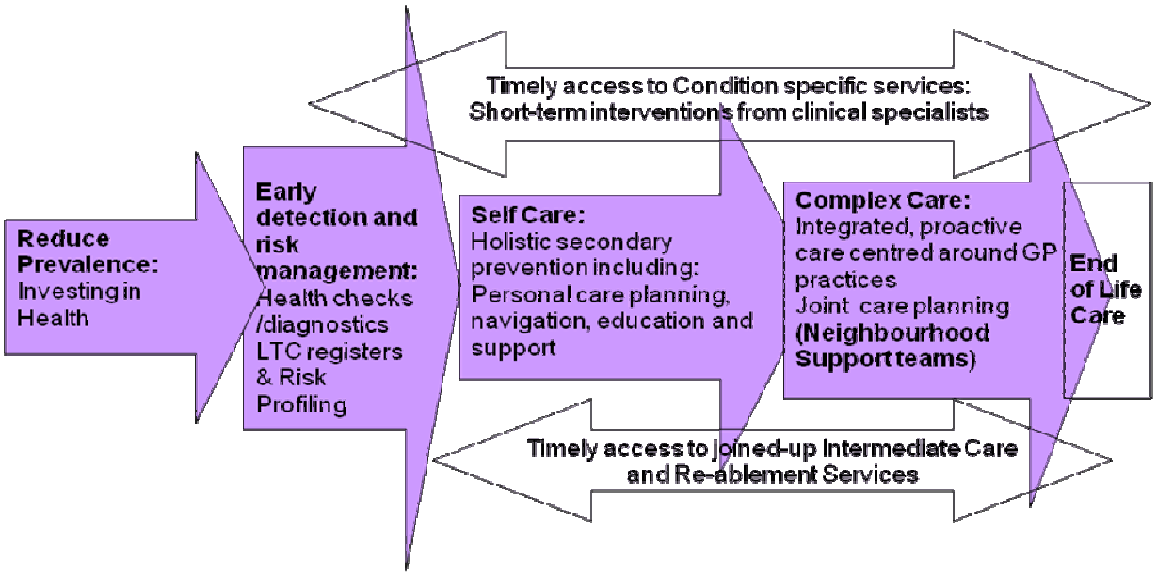
Where do we want to go next?

We've looked at the activities that support the journey to fully integrated care provision:

- Obtain sign up and co-operation between all organisations involved in integrated care implementation, including demonstrated commitment from leaders
- Identify options for optimal funding models, where service funding is directed to greatest areas of need
- Use shared access to knowledge information and IT systems to be proactive in managing shifting demands
- Enhance our ability to link care interventions to outcomes and greater ability to identify high risk clients by development of information systems that can collect, track and report on care activities
- Structure our workforce to ensure the best care and outcomes for local people
- Create more client centred hybrid roles characterised by single management and pooled funding
- Expand our JCR Service to improve capacity and effectiveness
- Create truly integrated multidisciplinary teams via the establishment of our NSTs
- Continue to work on reducing number of unscheduled hospital admissions, bed days and length of stay
- Continue to support the shift from acute to community working.

Our programme of work is responsive to priorities articulated in public health, NHS and Adult Social Care outcomes frameworks. By our interventions we are ensuring that people have a positive experience of care and support. Our single point of access will deliver health improvement by ensuring people get access to the right care in the right place in a timely and appropriate fashion. Our reablement service will enhancing quality of life for people with health and support needs and delay and reduce the need for care and support by providing person centred, appropriate care. Our NSTs will provide proactive, planned and co-ordinated intervention to achieve the outcomes important to our clients.

2.2 Plan for whole system integration



East Sussex – Whole Systems Model for Community Services

We have turned around our position of being a challenged economy and have established a programme of work built on joint decision making between health, social care and other partner agencies. Our transformation programme has a particular focus on our most vulnerable clients – frail elderly with long term conditions and is informed by rigorous consultation with clients, carers, multi-disciplinary teams across health and social care, and third sector involvement. It also includes working with the independent sector to improve quality of life in care homes, including dementia management and end of life care.

Pioneers in integrated care and support

East Sussex

Priorities for the programme are to:

- Create services that inform and empower clients to manage their own condition and enable them to be treated in settings closer to home and spend less time in acute settings
- Focused on secondary prevention by empowering clients to self-manage their condition better
- Better management (including self-management) of clients with Long Term Conditions.
- Use of large scale change techniques to engage local commissioners, providers and clients to identify existing best practice and implement across East Sussex.

Person centred care is fundamental to our approach – clients are actively involved in making choices about improving their health and well being through involvement in care planning and use of personal budgets. Understanding and addressing the needs of carers in service provision is seen as a key priority, particularly given the demographic challenges in East Sussex.

To increase preventative care we are developing services for people with low level social care needs, improving dementia diagnosis and support, and increasing our support for carers. To help people maximise independence and support people in the community we have invested in the Joint Community Rehabilitation Service, operational from April 2012. This brings together 220 health and social care staff from 8 professional groups into an integrated service with equitable access. The JCR is already seeing remarkable success in the numbers of people receiving rehabilitation and reablement then not requiring ongoing support on completion, even though 39% of clients are over 85.

We are developing pathways to support people with acute conditions to manage these in the community, and are working with the third sector on individual and community reablement approaches. We are working with GP practices to roll out multi-disciplinary team meetings across the county as a means of better responding to the needs of frail elderly people and those who live with long term conditions. This way of working will act as a foundation of the development of Neighbourhood Support Teams. We will further develop locality based multi-disciplinary teams tailored to meet the needs of the local population.

Clients, the general public and third sector are involved in a range of ways to help shape plans and priorities. Engagement includes:

- Regular engagement with strategic voluntary sector groups such as the Seniors forums, Councils for Voluntary Service, Community Networks
- Holding workshops and focus groups with different communities to agree on how integrated care delivery should be implemented
- Conducting surveys to gather public opinions and perceptions

As part of understanding and addressing the impact of proposed cuts to services, consultation is underway in East Sussex to identify how public services can integrate with unpaid contributions from families and communities to make the best use of available resources. Ideas include the provision of greater communication and support to help clients and their carers to access core information and advice about what is available in their area. This will include self help groups and community level initiatives with the voluntary sector to increase their capacity to provide preventative and up stream care.

We will be using our information portals to provide accessible information about the formal social care market. This includes information about personal assistants and micro care and support services - together with information about quality and how to access good financial advice. Greater use of the County Council information portal (East Sussex 1Space) and the ‘support with confidence’ scheme is seen as key to increasing awareness of available support.

In East Sussex, third sector organisations play a vital role in the sustainable delivery of health and social care to local populations. Through our Commissioning Grants Prospectus, launched in 2011, we have strategically invested resources in social capital related support to get maximum value out of the investment being made.

Future resource planning takes into consideration investment in third sector organisations which have a key role in support of delivery of prevention-based services for the whole population. We believe that this can help manage demand for formal health and social care interventions. Within this there is the scope to scale up third sector capacity to deliver long-term and complex support in order to promote the sustainability of NSTs and enable them to deliver holistic, person-centred care to clients.

2.3 Demonstrate commitment to integrate care and support across the breadth of relevant stakeholders and interested parties within the local area

Existing boards provide governance for integration initiatives across East Sussex. High level strategic direction for the integrated care agenda is driven by the Health and Wellbeing board. The Board (of which Healthwatch is a member) is committed to improving health and wellbeing across East Sussex, especially for people, places and communities who currently have the worst health outcomes. It will drive communication of a shared and comprehensive understanding of local health and wellbeing needs, and a clear strategy of how to meet them.

One important aspect of our integrated care governance implementation is the set up of our trail blazing Integrated Care Network (ICN). The ICN is the hub of our integrated care delivery, and was established to manage and oversee delivery of whole systems improvement across Health and Social care in East Sussex. This network brings together commissioners and providers, managers and clinicians, primary, community, secondary and social care and mental health to work collaboratively to identify, plan, and implement the programme of change.

We also have a number of partnership boards, with stakeholders across East Sussex to shape service developments, and ensure accountability for delivery. These boards make sure that we're involving clients and the public in crucial decision making, and include the Older People's Partnership board, Improving Life Chances, Mental Health, Learning Disability, and Carers Partnership boards.

Under the governance of our boards we have delivered a number of innovative initiatives. Highlights include:

- Creation of integrated multidisciplinary teams via the establishment of our Neighbourhood Support Teams. Our NSTs aim to deliver integrated personalised (health and social care) preventative and proactive support that equips clients, carers and their families with the knowledge and skills to facilitate self-care, well-being and promote independence. For each team the focus is on knowing their population and targeting the most vulnerable and managing their care. This is achieved in partnership with GP's and other partners (voluntary sector and mental health) through regular multi-disciplinary meetings, use of risk stratification tools and implementation of self-care techniques to empower clients and their carers to take a greater role in the management of their long term condition.

- Development of an East Sussex Joint Commissioning Grants Prospectus(JCGP) with voluntary organisations, which has led to clearer outcomes for commissioning in terms of value for money, quality, social capital and clear outcomes. The prospectus encourages innovation and economies of scale and supports opportunities for large and small voluntary organisations to work together whilst supporting mainstream objectives. Examples of this include Independent Living Service attendance at multi-disciplinary team meetings and our take home and settle 'home from hospital scheme'. Take home and settle is a voluntary service, supporting older people to remain independent in their own homes on discharge from hospital. Referrals can come from clients, ward nurses, GPs and friends and family. The service is free to the users, and includes visits and support at home for between 4 to 6 weeks

- Joint commissioning of Integrated Community Equipment Services (ICES) by Adult Social Care and local NHS commissioning partners. A pooled budget arrangement has been in place since 2007 to fund the provision of community equipment, minor adaptations and equipment for people with sensory impairments

- Creation of an Integrated Night Service (INS) during 2010 which is an integral part of the admission avoidance urgent care pathway. The service works closely with emergency duty teams in Adult Social Care supporting carer crisis situations, GPs, out of hour's service, and paramedic practitioners. The service reaches in to A&E departments to support re-direction home for clients who do not require acute admission.

- We have a ground-breaking approach to the commissioning and delivery of community based dementia assessment and diagnosis services, including a GP led service complemented by direct access to Alzheimer's Society Dementia Advisors (originally funded through a DH demonstrator site). This has included commissioners working with the University of Bradford to develop a postgraduate certificate in dementia studies for GPs.

2.4 Demonstrate capability and expertise to deliver successfully a public sector transformation project at scale and pace

We have excellent capability and expertise to successfully deliver transformation projects at scale and pace as demonstrated by our successful POPP implementation and the establishment of our joint community rehabilitation service.

Partnerships for Older Peoples Projects (POPP)

Between 2006 and 2008, ESCC was one of 29 local authorities in England to receive POPP (Partnerships for Older People Projects) funding from the Department of Health. It was a nationally regarded programme, with programme team members invited to present at a number of fora on outcomes.

Integrated services for POPP focussed on:

- Giving people information about home adaptations, equipment and community support
- Avoiding hospital admissions, including for those attending A&E
- Providing specialist care for people with mental health problems

During the two year programme more than 7,500 people accessed the services. For the years 2008/9 and 2009/10, the net benefit generated was 26%, or £5 returned for every £4 invested. The POPP programme helped to prove the case for the benefits of integrated care. It fully engaged local older people in planning investments, designing and evaluating the effectiveness of care services. It also proved that investing in partnerships to prevent people losing their independence can deliver good outcomes for clients and also deliver a positive financial return on investment.

Models developed by POPP for involving older people informed the need for effective engagement with older people through channels such as the East Sussex Seniors' Association (ESSA) and the Seniors' Forums. The POPP reference group's involvement in the joint health and social care Older People's Partnership Board enabled the lessons learned from POPP to be more embedded in the local community and future service design.

Joint Community Rehabilitation Service

We have worked systematically as commissioners and providers to deliver a three year transformational project to implement a JCR, operational since April 2012. This service brings together 220 health and social care staff from 8 professional groups into an integrated service with equitable access and is seeing remarkable success in the numbers of people receiving rehabilitation and reablement then not requiring ongoing support on completion. The JCR provides an integrated rehabilitation and reablement service operational over Eastbourne, Hailsham and Seaford, High Weald, Lewes and Havens and Hastings and Rother.

The project included significant stakeholder analysis and management and comprehensive stakeholder engagement, including extensive engagement with clients, carers and GPs. The redesign of service and care pathways necessitated an innovative way of redesigning the workforce and defining required training needs and location of staff. A number of quality and performance indicators were compiled, and the quality of service was actively monitored. The JCR implementation produced lessons learned for future integrated care deployments, and enhancement of the service.

JCR has outstanding success during their first year of integrated operation. Highlights of the service have been documented in the end of year report and include:

- 1000 admissions to hospitals prevented
- 8659 clients referred to JCR during 2012 – 2013
- 96% of clients satisfied or very satisfied with JCR service
- 74% of clients remained at home with no additional on-going services
- 32% of clients are aged between 75 and 84 years and 38% of clients are aged 85 and over

Targets have been achieved with quality and performance indicators reported regularly to sponsors and commissioners.

Staff Capability and Expertise
We have skilled and experienced staff to help us progress the transformation agenda. The commitment to staff training and development across the Health and Social care community in East Sussex is high. Training in programme management (MSP), project management (PRINCE2) and change management is backed up with significant business and clinical experience. Many of the project managers are clinically trained, which affords additional credibility for joint working with clinical subject matter experts.

Risk mitigation
Risks are managed as part of existing project activity, with a comprehensive risk and issues log developed for the programme. We would take this opportunity to revisit the risk log to reflect new ways of looking at risk in integrated environments, particularly optimum ways of risk sharing across integrated partnerships.

2.5 Commit to sharing lessons on integrated care and support across the system

East Sussex has a robust history of sharing successes and lessons learned between professional groups, across our geographic boundary areas and at a national level. We are committed to sharing lessons learned and successes across the wider community to contribute to earlier realisation of benefits.
Examples of this include:

POPP
The POPP programme team participated in a number of activities to disseminate lessons learned and share success of our widely regarded POPP implementation. These include participating in You Tube information videos, and presentation at public fora. In 2010, East Sussex presented at the Counsel and Care 5th National conference in London. Our programme team also worked closely with the National POPP evaluation team to analyse outcomes and lessons learned.
At the end of this time limited programme, the programme report contained 16 different documents and two DVDs to feed into the lessons learned agenda for development of services for older people.

Commissioning Grants Prospectus
Our Commissioning Grants Prospectus, launched in 2011, strategically invests resources in prevention and wellbeing services in the third sector. Our prospectus has awarded over £14m through 100 grants since the process began. The Prospectus approach has now expanded from initially just ASC investment to include NHS, Public Health, Children's Services and Safer Communities investment. This has reduced replication and increased overall efficiency of using grant-making methodology to commission local services. An independent evaluation by the Institute of Public Care commented on the effectiveness of the model noting that it was 70% cheaper to administer than tendering the equivalent number of contracts, and that our relationships with the voluntary sector improved by 30%. This effort at collaboration and partnership was recognised by a National Compact award in 2012, by the National Association for Voluntary and Community Action, and by the Cabinet Office Commissioning Academy as a model of good practice for valuing social capital. In addition, a panel of service users and carers developed an innovative scoring criteria approach which has been mainstreamed on an annual Council-wide basis.

Developing User Led Organisations
ESCC provided grants to fund our local Centre for Independent Living to support ten voluntary organisations to develop their user led capacity as part of a wider market development initiative. The team produced a user led outcomes (ULO) toolkit which has been promoted nationally to support clients to get involved in setting up and managing local services. The toolkit was presented at a regional ULO event hosted jointly by ESCC and the Department of Health South East with 100 voluntary organisations. The criteria developed in the toolkit have been fed into the Commissioning Grants Prospectus scoring criteria.

'Peer to peer' promotion, dissemination and learning networks
There are a number of clinical collaborative networks across Sussex, working closely with Adult Social Care, including community nursing teams and clinical supervision groups that share best practice. Our multi-disciplinary teams and neighbourhood support teams form client centred learning networks, where professionals share information to improve our quality and consistency of care and client experience. Team workers are already reporting that this enables them to gain a better understanding of each other's roles and the difficulties and pressures they all face.

Dementia in Acute Hospitals
In 2012, East Sussex Commissioners led a collaborative audit across Sussex Acute hospitals of the numbers of elderly clients admitted with dementia, comparing admission rates, length of stay and needs profiles – and those without dementia. It was found that twice as many older people in hospital have dementia than do the general population and those with dementia stayed on average 4 days longer, largely through presenting with more serious needs due to a possible delay in symptoms being identified. This drives the recommendation to include Mental Health services from the outset in NSTs plus opens up negotiations to develop a model of shared care in our acute hospital wards.

2.6 Demonstrate that its vision and approach are, and will continue to be, based on robust understanding of the evidence

What we do is based on firm foundations. Over the last decade we have significantly increased our use of evidence to shape our vision and implementation of integrated care in East Sussex. In 2004 we took the innovative approach of establishing community matrons and case finding based on the Evercare model. We have continued to base our decisions on national and local evidence and to learn from sources such as the Department of Health long terms conditions programme, Nuffield Trust, and research published via the King's Fund. We are constantly vigilant in monitoring emerging evidence nationally and also evidence gained from local implementation which is fed back into our programme review process.

Of particular relevance is evidence presented in the following publications:

- *The evidence Base for Integrated Care (Kings Fund and Nuffield Trust) 2011*
- *Urgent and Emergency Care (A review for NHS South of England) Kings Fund 2013*
- *Reforming payment for health care in Europe Nuffield Trust 2012*
- *Evaluation of the first year of the Inner West London Integrated Care Pilot (Nuffield Trust) 2013*
- *Integrated Services for older people (Audit commission) 2002*
- *Enabling people to live well (Health Foundation) 2013*
- *Long Term Conditions QIPP workstream as published on NHS networks website.*

Our business planning process ensures that evidence can be considered by our clinical networks and is used to inform implementation locally. We have a strong track record of using evidence to inform strategic commissioning across care pathways and service development, including the following:

Multi-disciplinary Team Meetings
The design of our proactive model of care includes the use of risk stratification to identify clients who are at risk of hospital admission. This has been developed over 10 years, starting with the use of PARR, and progressing to the Sussex CPN tool which is now used by 3 NHS organisations in Sussex and 6 elsewhere in the UK. Our current project develops this further through incorporating social care data as per Nuffield Predictive Models of Health and Social Care (2011)

Joint Community Rehabilitation Service
The JCR was developed in line with best practice guidance from the Department Of Health (2009) which demonstrates the continuum between reablement and rehabilitation. Care Services Efficiency Delivery modelling was used to establish investment levels and Key Performance Indicators for this service.

COPD Care Pathway
East Sussex CCGs have recently agreed additional funding for the community respiratory service. The business case draws on both local and national evidence, ensuring that the service model is in line with NICE clinical guidelines and standards, COPD and Asthma Outcomes strategy, Department of Health COPD Commissioning toolkit, and reflects local variation identified in the East Sussex JSNA.

Heart Failure Care Pathway
East Sussex has performed well against Quality Innovation Productivity and Prevention 2012 savings targets for heart failure. The realisation of benefits has been achieved by increased, systematic use of the heart failure pathway as defined in the NICE Quality Standards and Enhancing Quality Programme.

Admission Avoidance Care Pathway
The East Sussex admission avoidance care pathway is informed by evidence from the Kings Fund 'Avoiding hospital admissions' Sarah Purdy (2010).

3 Where do we need help from pioneer partners?

We need to be much clearer as commissioners and providers as to how we bring together person centred care. We would use this opportunity to better articulate what fully integrated care would look like, and ensure that we have a shared level of commitment to its successful implementation. There is immense will to integrate care provision amongst the public, carers, health and social care professionals, mental health and the third sector. However, the practical implementation of the programme across disparate organisations is challenging and we have identified a number of key strategic enablers that need to be addressed for whole systems integration in East Sussex:

- **Governance models**
  We need a system of governance that is overarching, across commissioners and providers, including mental health. This governance would secure commitment to our agreed plan of work and ensure transparency of commitment to resource re-distribution.
- **Risk management**
  A risk management approach is required that is appropriate to the scale of our ambitions. We currently have no whole system approach to risk management, and very much see that this is an area where we could benefit from pioneer partner support. The largest area of risk that we see is that involved in sustaining service delivery, whilst transforming to new models of care delivery.
- **Benefits definition and realisation**
  We understand that other health and social care economies have existing benefits methodologies, and would like to leverage lessons learned from adoption of these
- **Investment models**
  A number of options could be considered and part of the support we would like, would be to help with an options appraisal of suitable investment models for the East Sussex health and social care economy. Integration of budgets where one or more integration partners have financial difficulties is seen as a particular challenge
- **Shared information and Information Technology**
  Our ambitions to proactively anticipate demand on available evidence will be supported by implementation of integrated IT systems. As part of the programme of work, we need to identify how we can make the best use of existing resources, and optimise our use of IT
- **Organisational Design and Workforce Development**
  Transforming local services to meet future integration challenges will mean transforming the health and social care workforce to deliver care in different ways. The local workforce will need to be organised to ensure the best care and outcomes for local people. They will explore the need for new types of worker to meet future workforce requirements, and to identify the associated mix of skills required for these roles. Knowledge and experience can be shared and resources pooled, bringing benefits to individuals and organisations alike
- **Property and Facilities**
  From our JCR implementation, we know that examining the best way of co-locating teams is an essential part of service implementation. We need a proactive multi-agency approach to estates management that makes the best use of available resources.

4 Conclusion

The complexity of East Sussex provides the Pioneer Support Team with an excellent opportunity to test how national intervention can benefit challenged economies. From our solid foundation of delivery of integrated care initiatives we have a good grasp of what needs to be done to progress towards full integration. We do need help however, to shape our approach, and break down some of the roadblocks preventing us making the next step in our transformation journey. Testing in a complex economy makes sense for rolling out of lessons learned to areas with fewer challenges.

We appreciate that it won't be easy, but by allocating pioneer status to East Sussex at an early stage, benefits of integrated care could be realised earlier for a wide range of stakeholders at both a local and national level. Most importantly, benefits can be realised earlier for those people using our services - who remain central to our delivery vision.

East Sussex Health and Wellbeing Board

Healthy Lives, Healthy People

The East Sussex Health and Wellbeing Strategy 2013-2016

December 2012

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FOREWORD

I am delighted to present to you the first Health and Wellbeing Strategy for East Sussex on behalf of the East Sussex Health and Wellbeing Board.

We believe that everyone in East Sussex has the right to enjoy good health and wellbeing at every stage of their lives. Many of our residents enjoy a high quality of life and a better life expectancy than the national average but there are differences and inequalities within and between different parts of the county, and things that we could do better together to make further improvements and make the best use of the money we have available to us.

Our vision therefore is to protect and improve health and wellbeing in East Sussex and to reduce inequalities so that everyone has the opportunity to have a safe, healthy and fulfilling life.

The Health and Wellbeing Board is a partnership between Local Government, the NHS and the people of East Sussex. Members include local GPs, county councillors, the local Healthwatch and senior County Council officers overseeing Public Health, Adult Social Care and Children's services. The Board will be supported by an Assembly made up of a wide range of organisations from the public, private and voluntary and community sectors that are all interested and involved in improving local people's health and wellbeing and the wider factors that can affect this such as housing, employment, community safety and social isolation.

This new partnership gives us the opportunity to look across the whole health and care system, make sure it is well connected and change the way we work where it will improve outcomes, change behaviours and make the delivery of services more effective and efficient. We believe that this new approach will have a powerful impact – it will affect how individuals, families and communities support their own quality of life, how commissioners and service providers work together to improve the health and wellbeing of the whole population, and engage a much wider range of partners in our joint mission. There is already a lot of work going on to protect and improve people's health and wellbeing and reduce health inequalities. The Health and Wellbeing Board will take an overview of existing work by partnerships and agencies to ensure our efforts are joined up and that everyone has the opportunity to enjoy a better quality of life.

The East Sussex Health and Wellbeing Board members are committed and look forward to working with the public, patients, service users and carers, other partnerships and with a wide range of partners to deliver this strategy over the next three years.

Cllr Sylvia Tidy
Chairman
Health and Wellbeing Board

EXECUTIVE SUMMARY

This is the first Health and Wellbeing Strategy for East Sussex from the East Sussex Health and Wellbeing Board. It is based on the Joint Strategic Needs Assessment and other data sources such as local joint commissioning strategies and national research to identify the health and wellbeing needs of East Sussex residents now and in the future. For those interested in the evidence base, please see the accompanying Supporting Information Document.

The strategy also recognises the challenges we are facing including demographic and lifestyle changes and the economic climate as well as the opportunities that exist to improve health and wellbeing outcomes in East Sussex.

The strategy focuses on a small number of big issues where a more joined up approach will help to improve outcomes, reduce inequalities and deliver efficiency savings that could be re-invested in service improvements. The strategy is therefore not a long list of all the health and wellbeing issues or activities in East Sussex but focuses on a small number of big issues where the Board can make a real difference and sets out how those needs will be met through the commissioning of services, joint working and collective action.

Our vision is to protect and improve health and wellbeing and reduce health inequalities in East Sussex so that everyone has the opportunity to have a safe, healthy and fulfilling life. This is part of a broader partnership vision set out in the East Sussex Sustainable Community Strategy, Pride of Place, to create and sustain:

- A vibrant, diverse and sustainable economy;
- Great places to live in, visit and enjoy; and
- Safe, healthy and fulfilling lives.

The areas we will focus on over the next three years are:

- The best possible start for all babies and young children
- Safe, resilient and secure parenting for all children and young people
- Enabling people of all ages to live healthy lives and have healthy lifestyles
- Preventing and reducing falls, accidents and injuries
- Enabling people to manage and maintain their mental health and wellbeing
- Supporting those with special educational needs, disabilities and long term conditions
- High quality and choice of end of life care

In delivering the vision and our priorities we will:

- Take a whole life approach from conception to death and enable links to be made along the life course and at key life stages;
- Develop an integrated ‘whole system’ so that people get the right care and support at the right time and the best place whether in the community, primary, secondary or specialist care settings;
- Increase prevention and early intervention to improve people’s chances of a healthy life and to help us to manage demand for health and care services in the future;
- Reduce the inequalities in health outcomes that exist within and between different parts of the county and different groups of people, and improve access to information, advice and support;
- Work with public, private and voluntary and community sector partners to join up health, care and other services that affect people’s health and wellbeing; and
- Value and build on the strengths, skills, knowledge and networks that individuals, families and communities have, and can use, to overcome challenges and build positive and healthy futures.

This strategy is a framework for the commissioning of health and wellbeing services in the county. It will not replace existing commissioning plans, which will set out in much more detail the kinds of services being commissioned and where and how they will be delivered. The Health and Wellbeing Board will consider relevant commissioning strategies to ensure that they have taken into account the priorities and approaches set out in the Health and Wellbeing Strategy.

An action plan, setting out in more detail how the strategy will be delivered and how progress will be measured will be published alongside the final strategy in December.

1. A HEALTH AND WELLBEING STRATEGY FOR EAST SUSSEX

This is the first Health and Wellbeing Strategy for East Sussex from the East Sussex Health and Wellbeing Board. It is based on the Joint Strategic Needs Assessment and other data sources such as local joint commissioning strategies and national research to identify the health and wellbeing needs of East Sussex residents now and in the future. It sets out how those needs will be met through the commissioning of services, joint working and collective action.

In choosing which areas to focus on the Board:

- Looked at all the data available to us and identified a number of areas where, in East Sussex, we are statistically significantly worse than the England average;
- Considered the impact of changes to our population, lifestyles and life expectancy to see what kind of issues we might face in the future if we don't take action now;
- Looked at what is already being done to ensure the strategy would add value to – not duplicate – a wide range of other strategies and plans;
- Identified seven areas the Board proposed to focus on over the next three years; and
- Consulted widely on these proposals, listened to what people said, undertook an initial Equalities Impact Assessment and used this to inform the draft strategy. (Please see the accompanying Consultation Report for more detail).

The Board recognises and aims to add value to the vast amount of partnership work already underway to address people's health and wellbeing needs. The strategy is therefore not a long list of all the health and wellbeing issues or activities in East Sussex but focuses on a small number of big issues where the Board can make a real difference. It recognises the challenges we are facing due to demographic and lifestyle changes and other factors such as the economic climate as well as the opportunities that exist to improve health and wellbeing outcomes in East Sussex.

The strategy provides a framework for the commissioning of health and wellbeing services in the county. It will not replace existing commissioning plans, which set out in much more detail the kinds of services being commissioned and where and how they will be delivered, but instead will ensure these plans are aligned and help deliver the priorities and outcomes set out in this strategy.

The Joint Commissioning Board will translate the strategy's priorities into joint commissioning priorities, oversee annual joint commissioning strategies and approve and monitor the deployment of budgets (where they are pooled) and resources outlined in those strategies, ensuring the best use of available resources. Clinical Commissioning Groups' commissioning plans will also be informed by and help deliver this strategy. The Health and Wellbeing Board will consider these commissioning strategies and plans to ensure that they have taken into account the priorities and approaches set out in the Health and Wellbeing Strategy.

Some services will be commissioned and delivered by two newly established national bodies - NHS Commissioning Board will be responsible for commissioning primary care health services. For the period 2013-2015 the Board will also commission the Healthy Child Programme 0-5 years (including health visiting). Public Health England will take the lead for commissioning and providing a range of services such as national behaviour change campaigns, the prevention and control of infectious diseases and emergency preparedness and response.

The Board will work with a range of partners and partnerships across the public, private and voluntary and community sectors to strengthen the links between health, care and other services so that plans that affect health and wellbeing such as housing and housing support, community safety, education and skills, economic development, the environment, culture, leisure and community development help to promote individual, family and community health and wellbeing.

Throughout this document, where we refer to 'partners' we mean organisations in the public, private and voluntary and community sectors that commission and provide a range of services that promote individual, family and community health and wellbeing.

For those interested in the evidence base, please see the accompanying Supporting Information Document. A glossary of terms can be found on page 19 of this document.

2. WHERE WE ARE NOW

a) East Sussex – the place

East Sussex covers 1,725 square kilometres (660 square miles) and includes the boroughs and districts of Eastbourne, Hastings, Lewes, Rother and Wealden. East Sussex is predominantly rural in character, although almost 70% of the population live in urban areas (53.7% live in the coastal urban areas and 15.7% live in market towns).

East Sussex is the 5th most deprived county in England and experiences the highest levels of deprivation of all the counties in the South East. Deprivation is most concentrated in our coastal towns whilst also being experienced by some people living in rural areas. Some parts of the county experience:

- Higher rates of child poverty, poverty among older people, free school meals, fuel poverty, long term unemployment and young people not in education, employment or training. In parts of East Sussex 47% of children are living in poverty. Poverty and worklessness are closely linked to poor health outcomes;
- Higher levels of overcrowding – across the county 5.6% of the population live in overcrowded households, this is highest in Eastbourne at 8.6%, significantly worse than the England average. There is evidence that overcrowding, homelessness and living in temporary accommodation are all associated with poorer physical and mental health outcomes and can impair child development and educational attainment;
- Higher rates of violent crime, alcohol related crime, sexual offences and numbers of first time entrants into the youth justice system. Crime and the fear of crime can affect people's overall quality of life and their health and wellbeing. Research shows that between 44% and 50% of crimes in East Sussex are associated with alcohol and drug misuse and 90% of offenders have a mental health condition; and
- Lower GCSE achievement rates and higher rates of primary school exclusions. Acquiring skills and educational achievement enables children to realise their full potential and can impact on a range of outcomes including their employment prospects, income and physical and mental health in later life.

The geography of East Sussex poses some particular challenges as a combination of urban and rural localities can result in patchy service delivery and difficulty for rural residents to get to services.

b) East Sussex – the people

In 2011 the population of East Sussex was 526,700. 16% are aged 0-14 years old and 61% are of working age (15-64 years old). Older people make up a significant percentage of the population. 23% was of pensionable age in 2011 compared to 16% in England and Wales and 17% in the South East. Nearly 12% is aged 75+ compared to around 8% regionally and nationally. East Sussex is ranked the third highest of all 35 counties in England for percentage of the population aged 75+ and 85+. At district level, Rother is ranked highest of all districts and unitary authorities in the country for the percentage of the population aged 85+ and 90+ and second highest for the 75+ age group.

The total population of East Sussex increased by 34,400 people (7%) between 2001 and 2011, which is lower than the national and regional average. Growth rates in the districts and boroughs have been more variable: Eastbourne accounted for over a quarter (28%) of the county's population growth, with 9,700 additional residents since 2001, or a growth rate of almost 11%. At 5.8%, Lewes had the smallest growth in population over the period, followed by Rother at 6.1%.

About 36% of the county's households are one person households, higher than the national and regional average. Over half of these households are aged 65+. One person households are likely to rise and couples with children are expected to fall in the future. These figures are due to be updated in December 2012 to reflect the results of the 2011 Census.

Increasing life expectancy presents additional demands as it leads to more people living longer with one or more long term condition. As a consequence, the amount of health and social care support required and the cost of providing it will increase. In 2001, 19% of people in the county had a limiting long term illness (LLTI), a higher proportion than regionally and nationally. By 2026 the LLTI population is projected to increase in East Sussex to about 24% of the total population.

The proportion of people aged 65+ with limiting long term illness may increase to 48% of all people aged 65+. The proportion of people living in East Sussex with at least one type of disability is projected to increase slightly from almost 17% in 2010 to about 20% in 2026. This is mainly due to an ageing population. This data will be updated with the release of results from 2011 Census later in 2012.

According to the 2001 Census almost 10% of our population, nearly 51,000 East Sussex residents, provide unpaid care to family members, friends, neighbours or others because of long term physical or mental health problems, disability or problems relating to old age. Carers are of all ages and circumstances including young carers, working carers and parent carers, but the majority are aged 50-64 and nearly 20% of unpaid carers are providing care for more than 50 hours a week. Results of the 2011 Census, due from November 2012, will provide a more up to date picture. Supporting carers improves their health and wellbeing and those for whom they care. Carers also help reduce demand on health and social care services, for example, by reducing hospital admissions and delays in discharging people from hospital.

East Sussex is less ethnically diverse than the South East region or nationally, with 10.5% of the county's population in Black and Minority Ethnic (BME) groups compared to 14% in the South East and 17% in England. At about 13%, Eastbourne and Hastings have the highest proportion of BME groups compared to the rural districts. Since 2001, BME groups have increased in East Sussex and in all its districts, as well as nationally and regionally. The largest rise occurred in Hastings with an increase of almost 7% since 2001. Among the BME groups, the 'Other White' and 'Asian' ethnic groups show the highest proportions in the county and in all districts, except for Hastings where there is a higher proportion of people in 'Black' ethnic groups. This data will be updated with the second release of data from 2011 Census due in November 2012.

c) East Sussex – health and wellbeing

Whilst many people in East Sussex are relatively healthy and can expect to live a long life, some people do not experience this and there are inequalities across the county. Residents in the poorest parts of East Sussex are not only more likely to die earlier but they will also spend a greater proportion of their shorter lives unwell.

The most recent Local Needs Profiles, published in September 2012, conclude that:

- Many deaths and illnesses can be avoided by enabling people to live healthy lifestyles. Local data clearly shows that there are some significant issues around smoking; alcohol and drug misuse; obesity and physical inactivity; sexual health; vaccinations and immunisations.
- There is a need to improve the identification and treatment of people with chronic diseases and long term conditions where the prevalence is significantly higher than England. Lifestyle factors including smoking, excessive alcohol consumption, physical inactivity and poor diet increase the risks of developing a long term condition. Deprivation is also associated with an increased risk of some long term conditions with the rates and severity of disability being greater in more deprived areas.
- Cancer is a high priority in East Sussex with particular areas in the county showing significantly higher rates than England for specific cancers. Improvements can be achieved by lifestyle changes, improved access to screening and earlier diagnosis to increase the scope for successful treatment.
- The prevalence of depression and dementia are significantly higher than England. The prevalence of psychoses is significantly higher than England in Hastings and Rother. The rate of self-harm admissions is significantly higher than England in Hastings and Lewes, and Eastbourne has a mortality rate from suicide that is significantly worse than England.
- Hastings has significantly worse hospital admission rates for a range of different injuries including the rate of children and young people aged under-18 years admitted to hospital due to injuries. When compared to England, Hastings has a significantly worse admission rate for falls amongst older people. Road injuries and deaths are significantly worse than England in all districts and boroughs except Eastbourne. All districts and boroughs except Lewes have significantly worse admission rates than England for burn injuries.
- Most people approaching the end of life would prefer to be cared for at home. Data shows that the percentage of deaths at a persons own residence is significantly worse than England for all

districts and boroughs except Lewes. It also shows that the percentage of terminal admissions to hospital that are emergency admissions is significantly higher than England.

- Life expectancy is above the national average for both men and women in East Sussex, but there is significant variation across our districts and boroughs. On average men in Lewes live for 3.7 years longer than men in Hastings and women in Lewes live for 4 years longer than women in Hastings. At an electoral ward level in East Sussex, the gap between the two wards with the lowest and highest life expectancy is just over 15 years. Within East Sussex, Hastings has significantly worse life expectancy at birth and at age 65 years compared to England. Hastings also has significantly worse disability free life expectancy compared to England.
- Local data for people with learning disabilities shows that East Sussex is worse than the England average for the proportion of eligible adults with a learning disability having a GP health check; the percentage of emergency hospital admissions and the percentage living in non-settled accommodation.
- National research shows that some groups of people experience worse health and wellbeing than others for example some Black and Minority Ethnic groups have an increased risk of developing diabetes, stroke and renal disease and people who are homeless or are living rough, in hostels or night shelters have significantly higher levels of mental and physical ill health and premature death than the general population. Carers are more likely than the rest of the population to suffer depression and develop other health problems including back injury and high blood pressure.

Local Needs Profile data showing these and other areas where we are statistically significantly worse than the England average can be found in the accompanying Supporting Information Document.

d) East Sussex – the challenges

As a nation and a county, we are living longer. Over the last 30 years, life expectancy has risen significantly and deaths from major illnesses such as heart disease have fallen. However, compared with other parts of the country we continue to perform poorly in some key areas and there are persistent inequalities in life expectancy and healthy life expectancy between some parts of the county - a challenge that is common across England.

Our ageing population means rising numbers of frail older people and people living with one or more long term conditions. Several conditions are becoming more common, in part reflecting lifestyle changes, for example obesity and excessive alcohol consumption are leading to an increase in type 2 diabetes, arthritis and chronic liver disease. The prevalence of mental health has also continued to rise.

At the same time we have had rising numbers of children requiring statutory social care support and there is widespread recognition of the long term impact on children when parents and carers cannot provide a good standard of care, pointing to the importance of effective early intervention to support vulnerable families and young people.

The expectations of patients, service users and the public are rising with more and more of us expecting greater choice, better quality and more tailored services in more convenient locations.

Meanwhile, we are experiencing difficult financial times with far less money to spend on public services than before and a poor economy which is affecting individual and family finances.

All of these pressures combined means that doing the same things in the same way will not be affordable in future. We have to look seriously at how we can continue to protect and improve health and wellbeing and reduce inequalities within the resources available to us. We believe the approaches we have set out in this strategy will help us achieve that.

e) East Sussex – the opportunities

Despite the very real challenges we are facing in the county we have much to build on to improve health and wellbeing outcomes in East Sussex.

Our vision of coordinated and integrated health and wellbeing services is not new – the NHS, local public services providers and the voluntary and community sector have worked together for many years to develop and deliver a ‘joined up’ approach to health and wellbeing and to improve the experience of patients and service users in East Sussex.

There are a number of well established joint commissioning boards, partnerships and delivery networks in East Sussex that already make a significant contribution to individual and community health and wellbeing through preventative services, diagnosis, treating people when they become ill, reducing health inequalities and improving the social, environmental and economic factors that affect people's health and wellbeing.

The county is served by a range of primary care providers such as GP surgeries, dentists and community pharmacies. In terms of secondary and acute care, East Sussex Healthcare NHS Trust provides two district general hospitals in Hastings and Eastbourne, five community hospitals and a range of community health services. Brighton and Sussex University Hospitals NHS Trust provides hospitals in Brighton and Hayward's Heath, and Maidstone and Tunbridge Wells NHS Trust provides Pembury Hospital in Tunbridge Wells. Sussex Partnership NHS Foundation Trust provides specialist NHS mental health, learning disability and substance misuse services.

In April 2013 East Sussex County Council will take over responsibility for a range of public health services, from encouraging healthy lifestyles to commissioning drug misuse and sexual health services. Just as significantly, the reformed public health system gives the council and its partners in the public, private and voluntary and community sectors an unprecedented opportunity to take a far more strategic role in promoting public health and integrating it into a much wider range of services.

A range of public sector organisations provide invaluable services that contribute to health, social care and wellbeing including county, district and borough councils, the police and fire service. Our diverse voluntary and community sector provides a range of invaluable community based health, care and wellbeing services such as hospice care, support for carers, advocacy services and community development, capacity building and representation. The private sector also makes a valuable contribution by providing services, ensuring workplaces are safe and healthy and providing much needed employment for local people.

This strategy recognises and aims to add value to this work – not just 'universal' services that are available to everyone, but also by targeting support for particular groups of people and geographic areas and working to improve and develop more joined up services, for example community based services and greater integration between health, care and wellbeing.

There have been a number of important developments recently such as 'walk in' surgeries in Hastings and Eastbourne and major schemes to help local businesses grow, develop transport links, improve access to broadband and provide more supported housing and extra care housing developments for older people, disabled people and people with mental health conditions. These and other developments contribute to health and wellbeing by making healthcare more accessible, creating jobs, enabling more people to access online information, advice and support and enabling people to live independently.

3. WHERE WE WANT TO BE

a) Our Vision

Our vision is to protect and improve health and wellbeing and reduce health inequalities in East Sussex so that everyone has the opportunity to have a safe, healthy and fulfilling life. This is part of a broader partnership vision set out in the East Sussex Sustainable Community Strategy, Pride of Place, to create and sustain:

- A vibrant, diverse and sustainable economy;
- Great places to live in, visit and enjoy; and
- Safe, healthy and fulfilling lives.

b) Our Priorities

This strategy focuses on a small number of big issues and where a more joined up approach will help to improve outcomes, reduce inequalities and help to manage or reduce demand in future years.

The strategy is therefore not a long list of all the health and wellbeing issues in East Sussex but focuses on a small number of big issues where the Board can make a real difference.

The areas we propose to focus on over the next three years are:

- The best possible start for all babies and young children;
- Safe, resilient and secure parenting for all children and young people;
- Enabling people of all ages to live healthy lives and have healthy lifestyles;
- Preventing and reducing falls, accidents and injuries;
- Enabling people to manage and maintain their mental health and wellbeing;
- Supporting those with special educational needs, disabilities and long term conditions; and
- High quality and choice of end of life care.

c) Our Approach

We aim to deliver our vision and achieve our goals by:

i) Taking a whole life approach

We will consider health and wellbeing from conception to death. Although each life stage deserves particular attention, a whole life approach enables links to be made along the life course. By taking this approach we want to ensure that, in East Sussex:

- **Every child has a good start in life:** a safe, healthy and happy childhood provides the foundation for every child to thrive and achieve their potential.
- **Children and young people develop well:** the physical health and mental wellbeing of children and young people coupled with good educational achievement are essential to a good quality of life and good chances in adulthood.
- **Adults live healthy lives and have healthier lifestyles:** alongside other factors such as poor housing and unemployment, unhealthy lifestyles can lead to a range of physical and mental health problems later in life and, in some cases, a lower life expectancy.
- **Workplaces promote health and wellbeing:** unemployment can affect people's health, healthy employees are more productive, and workplaces can be used to promote healthier lifestyle choices.
- **Older people live healthy and independent lives:** as people live longer it is essential that older people have a good level of health and wellbeing to enable them to live fulfilling and independent lives.
- **High quality and choice of care at the end of life:** everyone who is approaching the end of life deserves equal access to the highest quality end of life care and to die in their preferred place of death.

ii) An integrated, whole system approach to health and wellbeing

We want to build on the work already taking place to close the traditional divide between health, social care and other services that affect people's health and wellbeing so that individuals get 'joined up' services that address their needs. This involves joining up every aspect of designing, commissioning and delivering services from prevention and early intervention through to diagnosis, treatment and care as well as re-ablement, rehabilitation, health improvement and promotion services to ensure people get the right support, in the right place, at the right time. A 'whole system' is not just about getting different organisations across the public, private and voluntary and community sectors working together to tackle ill-health and reach beyond this to address the social, environmental and economic factors that can affect health and wellbeing – this already happens in East Sussex – it is also about designing a system and gathering and sharing local information and knowledge to understand the effect that services and changes in one part of the system have on others, for example the impact of access to green space, leisure services, transport choices or planning decisions on tackling obesity.

iii) Increasing prevention, early identification and early intervention

Prevention, early identification and early intervention is crucial across all aspects of health and wellbeing from identifying early parents who are likely to need support to enabling people to take action or take up services that help them prevent problems arising or getting worse. There are many reasons why people tend to seek help when they have reached a crisis including the stigma

associated with some health and wellbeing issues, the fear of prejudice, the barriers people face to changing lifestyles or other issues – men, for example, are less likely to seek help than women. We will increase our focus on prevention, earlier diagnosis and early intervention along the life course including identifying those who need support with parenting, working with partners to reduce risks and promote health and wellbeing, intervening as soon as possible to tackle problems that have already emerged and enabling people of all ages to make changes or seek help earlier to avoid or delay the need for higher-dependency care and support.

iv) Reducing inequalities and improving access to information, advice and services

We are committed to helping everyone in East Sussex to maintain and improve their health and wellbeing but we also need to target some of our activity to those individuals, families and communities that are experiencing the worst health and wellbeing outcomes currently and to 'narrow the gap' between the best and worst outcomes in the county. Poverty and deprivation is experienced by some communities in East Sussex, can affect all types of families and households from single parents or large multi-generation households to older people living alone, and is known to have a substantial impact on physical and mental health, wellbeing and life chances. Information and advice is also crucial in giving everyone better choice and control over their health and wellbeing including signposting people to relevant health, care and other services such as housing support, social activities and online resources.

v) Joining up health, care and other services that promote health and wellbeing

A wealth of evidence, most recently presented by The Marmot Review of health inequalities, identifies the impact wider social, economic and environmental factors can have on individual and community health and wellbeing. We recognise the impact and contribution that housing, educational attainment, employment, community safety, transport, culture, leisure and the physical environment has within all seven priorities within this strategy. For example, the relationship between alcohol misuse and crime; the impact housing conditions can have on physical health, falls and injuries; the role supported housing and extra care housing schemes play in providing an alternative to residential care and enabling people to remain independent for longer; and the availability of open spaces, cycle paths and leisure facilities to encourage physical activity. The East Sussex Strategic Partnership (ESSP) already has a strong focus on these areas through its Sustainable Community Strategy, Pride of Place. This strategy is linked to that broader partnership vision and the Health and Wellbeing Board will work with partners and partnerships to strengthen the links between health, care and other services that impact on health and wellbeing and contribute to delivering the priorities in this strategy.

vi) Valuing and building on individual, family and community strengths

Health, care and other professionals have traditionally focused on the needs and problems that individuals, families and communities face. We value and want to help release the strengths, skills, knowledge and networks individuals, families and communities have as these can help them overcome challenges they may face, maximise independence, choice and control and help to build positive, happy and healthy futures. This 'asset based' approach is not new in East Sussex: building individual, family and community capacity and resilience is one of the main aims of many of our local voluntary and community sector organisations and a key objective of the East Sussex Commissioning Grants Prospectus and the Family Key Worker initiative. There has also been an increasing focus on re-ablement which helps people to do things for themselves rather than doing things to or for them, building on what people currently can do and supporting them to regain skills to increase their confidence and independence.

4. OUR PRIORITIES

a) The best possible start for all babies and young children

We know much more now than we did 10 years ago about the impact on children's long term emotional and intellectual development of not getting a good start in life. The first years, particularly the first 12 months, are a period in which good, loving care is essential for good physical and mental health and for the development of key communication and social skills. This is why successive national reports and Government policy statements have emphasised the need to identify vulnerable parents and give them the support they need to nurture their children. Failure to get the care they

need in infancy leads to poor outcomes for children not just in education but in their wider health and wellbeing. In East Sussex we know there are significant gaps in outcomes when children are assessed at primary schools at age 5 with only 49% of children in Hastings, for example, reaching the expected benchmark level for language and communication skills. A good start in life can also be affected by parents' health, wellbeing and lifestyles. For example, smoking during pregnancy increases the risk of miscarriage, low birth weight and still birth. On average 17% of pregnant women in East Sussex smoke rising to 23% in some parts of the county – significantly higher than the England average.

What we plan to do: Over the next three years we will ensure sufficient capacity is identified within midwifery, health visiting and children's centre services to provide high quality targeted support to all vulnerable parents who need it. We will roll out across the county an integrated approach to identifying those who need extra support and coordinating that support with regular meetings between all relevant services in local areas to plan and review support to the parents and families who most need it. We will ensure that all pregnant women who smoke are offered support to give up, targeting our efforts particularly towards those areas of the county with high levels of smoking during pregnancy. We will also increase breastfeeding support for women in the first five days after birth, particularly young women in more deprived areas where breastfeeding rates are currently lower. Families whose babies have special educational needs or disabilities will have coordinated, personalised specialist support planned through a "single plan". Making sure we support those who most need it, in a way which is really effective, requires the effort and cooperation of a wide range of organisations and individuals in health, care and other services. This more joined up and integrated approach is crucial to the long term health and wellbeing of children, families and communities.

What we aim to achieve: We want babies and young children to develop well and be safe and healthy. To achieve this outcome we want to see more families with babies given targeted "early help" support, improved rates of infant immunisation and vaccination, a reduction in the rate of referral to children's social care, and a narrowing of the gap in the skills development of young children across the county measured through the Early Years Assessment of personal, social and emotional development and communication, language and literacy skills at age 5. We would be looking for further improvement in the proportion of mothers choosing and able to breastfeed their babies given the well researched health benefits this brings for mother and baby and for fewer women smoking in pregnancy.

b) Safe, resilient and secure parenting for all children and young people

Good parenting is essential to the health, safety and wellbeing of children of all ages. The vast majority of parents in East Sussex are good parents providing a warm, safe and secure home life. However, in the case of some children and young people, we know that their parents struggle to keep them safe and to support their mental and physical development. East Sussex has seen a growing number of children and young people requiring support from statutory social care services in recent years, including rising numbers of children who need to be cared for through fostering and adoption. Between 2006 and 2011 the rate of children with a statutory Child Protection Plan rose from 36 to 60 children per 10,000. The number of Looked After Children increased from 445 to 589 in the same time period.

The reasons behind poor parenting are complex and vary from family to family. They can include poor physical or mental health of parents, substance or alcohol misuse or addiction, or the presence of domestic abuse in a household. They can also include for some parents a struggle to manage their child's behaviour, health conditions or disabilities, a lack of suitable role models or practical help in life, and difficulty understanding how to meet a child's needs consistently. Often families where these things are present also have a range of services trying to address the needs of various family members, making the issues even more complex.

What we plan to do: Over the next three years we will enhance the capacity and leadership of targeted early help services for parents who are struggling to parent effectively and ensure quick decisions and actions are taken where it is clear that parents do not have and cannot develop the capacity to provide good enough care for their children. We will invest in high quality training for all those who work with vulnerable families and ensure that support is streamlined and coordinated including through family key workers where appropriate. Our approach will be one which is designed

to build on the strengths of families and their wider networks, developing resilience and independence.

What we aim to achieve: We want parents to be confident, able and supported to nurture their child's development. To achieve this outcome we expect to see more families given targeted early help support, fewer referrals to children's social care and fewer young people entering the criminal justice system. We aim to improve outcomes across the board for the children and young people in families supported, including in educational attainment, economic wellbeing and health outcomes.

c) Enabling people of all ages to live healthy lives and have healthy lifestyles

Unhealthy lifestyles such as excessive alcohol consumption, smoking, poor diets or a lack of exercise can lead to a range of health conditions including liver and heart disease, hypertension, type 2 diabetes, stroke and cancer and are a major cause of hospital admissions and preventable death.

It is estimated that 23% of the East Sussex adult population are drinking at increasing or higher risk levels. In 2010/11 alone 7,483 people (all ages) were admitted to hospital with an alcohol attributable condition and 1,563 with an alcohol specific condition. East Sussex is significantly worse than England for the percentage of children and young people using alcohol. Drinking amongst young people can be associated with issues such as offending, truancy, drug misuse and alcohol related health conditions in later life. Alongside the health and wellbeing impacts and the economic burden of loss of employment and reduced capacity to work, there is a strong link between alcohol misuse and crime and the harm caused to individuals, families and communities from alcohol consumption is considerable. In East Sussex it is estimated that between 44% and 50% of violent and acquisitive crime, such as burglary, is associated with alcohol or drug misuse.

There are over 1,000 smoking related deaths in East Sussex each year – more than the combined total of the six next greatest causes of preventable deaths. Smoking is also linked to other issues such as crime and fires. 90% of smokers begin smoking before the age of 19 and in East Sussex it is estimated that around 15% of children aged 14-15 smoke. Smoking in pregnancy can cause miscarriages and perinatal deaths yet on average 17% of pregnant women in East Sussex smoke, rising to 23% in some parts of the county. Smoking is also the biggest cause of health inequalities in the UK accounting for half the difference in life expectancy between richest and poorest. Nationally the proportion of the population who smoke has fallen and this is the case overall for East Sussex with self reported smoking rates falling to around 17% in 2011, although rates of smoking in Hastings and Eastbourne appear to have fallen very little or not at all.

Across East Sussex it is estimated that almost 25% of adults are obese and this rises to 27% in Hastings which has significantly higher rates of obesity than the England and East Sussex average. In 2011 1/5th of 4-5 year olds and almost 1/3 (31%) of 10/11 year olds were obese or overweight. Despite actions to address obesity, levels of physical activity amongst children, young people and adults in some parts of the county have not significantly increased and there has not been a significant increase in people eating at least 5 portions of fruit and vegetables per day. Obesity increases the risk of a number of physical health conditions which can ultimately curtail life expectancy and can also lead to social stigmatisation and bullying. A major benefit of weight loss is that it improves not just one risk factor but the entire risk-factor profile. Even modest weight loss (5-10% of body weight) can have significant benefits. Severely obese individuals are likely to die on average 11 years earlier than those with a healthy weight, (13 years for a severely obese man between 20 and 30 years of age). This is comparable to the reduction in life expectancy from smoking.

For this first strategy we have chosen to focus on alcohol misuse, smoking and obesity. This does not mean that other issues are not important. In particular the Board recognises the need to maintain effective multi-agency partnership work to reduce the demand and supply of illegal drugs, to build recovery and support people to live a drug free life. It is also important that sexual health services continue to be planned effectively.

What we plan to do: Over the next three years we will support the development of a more joined up, integrated and multi-agency approach to alcohol misuse, tobacco control and obesity. This includes an enhanced alcohol care pathway - from prevention through to recovery and involving a wide range of partners; developing new cross-sector multi-agency plans for Tobacco Control and Obesity Prevention. We will work with partners to strengthen the links between health, care and other services and develop systems that enable those who have a contact with people to have the

knowledge and skills to provide brief advice and refer them to appropriate services or encourage lifestyle changes. We will ensure that all of our health improvement services are underpinned by knowledge of what works best in supporting people to change their behaviour.

What we aim to achieve: We want more people to have healthy lifestyles to improve their prospect of a longer, healthier life. To achieve this outcome we would expect to see a reduction in the proportion of adults drinking at increasing and higher risk; a reduction in the proportion of the population who smoke; increased rates of physical activity; more people eating healthy diets; and a reduction in alcohol related crime. Over the longer term we would expect to see a reduction in alcohol, smoking and obesity related preventable deaths and an increase in healthy life expectancy. We expect to see improvement across the county, but faster improvement in those areas currently experiencing the worst outcomes.

d) Preventing and reducing falls, accidents and injuries

Children and young people

Accidents and learning how to play safely and stay safe are part of growing up, but children should not be injured in accidents that can be prevented or be deliberately harmed. Between 2009/10 and 2010/11 there were 2,885 admissions to hospital in East Sussex for under-18 year olds who were injured in accidents or deliberately. 41% of these were caused by falls, particularly amongst younger children. 11% were deliberate harm – either assaults or self-harm. Another significant cause of accidental injury was road traffic accidents with 20% of accidental injuries for 11-16 year olds resulting in this way. Hospital admissions as a result of accidents have a high correlation with deprivation in local communities with significantly higher admission rates in some of the more deprived wards in Hastings and Rother.

What we plan to do: Over the next three years we will carry out more research and analysis to better understand the causes of falls, accidents and injuries amongst children and young people so that interventions can be targeted at those at greatest risk of harm. Based on good intelligence and best practice we also want to see a more integrated, evidence based approach to preventing and reducing falls, accidents and injuries amongst children and young people such as coordinated accident prevention activity and campaigns, home safety checks and equipment schemes and parenting support. This requires a multi-agency approach including health, care, housing, road safety, schools, the police, fire service and family support services.

What we aim to achieve: We want fewer children and young people to have preventable accidents or suffer deliberate harm by others or themselves. To achieve this outcome we would expect to see a reduction in the admission rate of children and young people to hospital for unintentional and deliberate injuries and self-harm.

Older people

Falls are the most common cause of accidental injury amongst older people in the UK. In most cases, falls are preventable. In 2008/09 South East Coast Ambulance Service responded to 14,797 calls for falls in East Sussex, over 70% of these related to people aged over 65. There were more than 5,870 falls related emergency admissions in East Sussex in 2010/11, 75% were people aged over 65 and 528 admissions were due to hip fracture with an average stay in hospital of 8 days. 10% of care home admissions are prompted by hip fractures and up to 20% of patients admitted from home will be moved into residential or nursing care homes as a result of hip fracture. With a large and growing older population, coupled with local trend data, falls, hip fractures and hospital admissions are expected to increase annually by 2%.

What we plan to do: Over the next three years we would expect to see a greater focus on prevention and early intervention and more joined up support 'closer to home' for those who do fall or suffer an injury and require rehabilitation, re-ablement or other services to help them lead an active, safe and independent life. We want to drive forward work in progress to develop a fully integrated falls prevention, treatment, rehabilitation and education service for older people by enhancing the current falls and bone care pathway with stronger links between community based support, primary care and secondary care settings as well as between health, care and other services.

What we aim to achieve: We want fewer older people to fall and injure themselves for the first or subsequent times. To achieve this outcome we would expect to see fewer first and preventable

second fractures in over 65's; fewer over 65's using secondary care due to a fall; and fewer over 65's using emergency ambulance services due to a fall.

e) Enabling people to manage and maintain their mental health and wellbeing

There are higher than national average levels of depression, psychosis and hospital admissions for self-harm in some areas in East Sussex. Many things can increase a person's chance of becoming depressed or developing other mental health conditions – bereavement, substance misuse, isolation, school bullying, workplace stress or debt for example. Carers and people with chronic or long term health conditions or disabilities are also at greater risk of developing mental health conditions, and people with mental health conditions are also more likely to experience poorer physical health outcomes. Spotting problems early and supporting people before things get worse is therefore of critical importance and everyone's business. Community based and secondary care based mental health services are already working well together and delivering positive outcomes for those diagnosed with a mental health condition. However, more needs to be done to break down the stigma associated with mental health, to identify people at risk earlier to help prevent their condition becoming more severe, and to support them and their carers to manage and maintain their mental health in ways that best suits them.

What we plan to do: Over the next three years we want to see the support pathway for children, young people and young carers with emerging mental health needs developed to ensure it is clear and that the best use is made of the different services and community based support on offer. We want to see an acceleration of work underway to develop an integrated and 'whole system' approach to mental health care for adults, older people and their carers by enhancing the mental health care pathway from prevention, early identification and advice through to care planning and recovery. We also want to see a more personalised approach within all care settings. To support physical health, this enhanced care pathway needs to be aligned with care pathways for long term conditions and have clearer links to other services such as supported housing and housing support.

What we aim to achieve: We want people of all ages to experience good mental health and wellbeing and ensure those with mental health conditions and their carers are able to manage their condition better and maintain their physical health. To achieve this outcome we would expect to see more people of all ages who have, or are at risk of developing, a mental health condition being identified, diagnosed, supported and treated earlier; more people, especially children and young people, using community based support; more people with more severe needs having a comprehensive care plan; fewer hospital admissions for self-harm ; fewer suicides; and improved physical health for people with mental health support needs.

f) Supporting those with special educational needs, disabilities and long term conditions

Special educational needs and disabilities

It is estimated that 6% of the population has some form of disability although not all will need intensive help and support. The incidence of disability has risen fastest amongst children and trends indicate increasing numbers of children being reported as having complex needs, Autistic Spectrum Disorders and mental health issues. We estimate that there are 14,229 disabled children aged 0-19 in East Sussex. There are over 2,200 2-19 year olds with a statement of special educational needs (SEN) in East Sussex and around 11,000 young people who do not have a statement but who may require support during transition to adulthood. Over the next seven years it is estimated that 600-800 young people in the county will need ongoing support after leaving full time education as a result of a disability.

We estimate that there are more than 2,000 adults with learning disabilities in the county, a number that is predicted to grow by 10% by 2020 in part due to improved health care resulting in an increase in life expectancy. The number of infants with profound and multiple learning disabilities surviving into adulthood and the number of older people with learning disabilities are also expected to increase as their life expectancy increases. There is evidence to suggest that disabled people have poorer health outcomes and reduced life expectancy compared to the general population.

What we plan to do: Over the next three years we want to see a more person centred, coordinated approach to supporting the health and wellbeing of those with SEN, physical and learning disabilities

and their parents and carers. We want to see more children with a coordinated support plan for health, social care and education and personal budgets, as well as earlier assessment of their needs.

What we aim to achieve: We want those with special educational needs, physical and learning disabilities to enjoy better health and wellbeing and a longer life expectancy. To achieve this outcome we would expect to see more children with a coordinated support plan for health, social care and education and better health outcomes and better quality of life for those with SEN, physical and learning disabilities.

Long term conditions

There are a number of conditions that could be classified as long term including epilepsy, diabetes, respiratory disease, heart disease, stroke, asthma, arthritis and dementia. Whilst many are age related some can develop in childhood. It is estimated that there are over 158,000 people in East Sussex living with one or more long term condition and many more who have not yet been diagnosed. Some of those affected will have severe symptoms and be at higher risk of hospital admission, but many will be leading full and active lives with only occasional contact with health and social care professionals. Although not usually referred to as a long term condition, we are including dementia within this priority as some areas within East Sussex have the highest dementia prevalence in the UK and this is projected to rise significantly over the next decade. People with long term physical health conditions can also develop a mental health condition or disability as a result of their condition and some disabled people, people with learning disabilities and mental health problems may be more likely to develop a long term condition. As our population ages the number of people with one or more long term condition is likely to rise. We therefore need to achieve more with the resources we have so that we can meet expectations and future demand. Encouraging healthy lifestyles from an early age is critical to reducing the likelihood of developing long term conditions. However, diagnosis also needs to be made earlier so that people can be supported onto the best care pathway as quickly as possible before their condition becomes more severe.

What we plan to do: Over the next three years we will support the development of a more holistic, integrated and 'whole system' approach to long term conditions with earlier diagnosis and care planning and more joined up services to support patients and their carers to manage their condition better. We want to see mental health support integrated into primary care and chronic disease management care pathways and the roll out of multi-disciplinary Neighbourhood Support Teams across the county. We also want to see integrated health and social care workforce development sustained to ensure patients and their carers are supported to understand and manage their condition better, including through maintaining healthy lifestyles.

What we aim to achieve: We want people with chronic or long term conditions to be diagnosed earlier and provided with more personalised care in the community or at home. To achieve this outcome we would expect to see fewer hospital admissions for long term conditions and improved quality of life for those who are living with them and their carers.

g) High quality and choice of end of life care

On average there are 6,526 deaths in East Sussex each year. Most people approaching the end of their lives want to be cared for and die at home, which for some is a residential care home or nursing home, or to be cared for and die in a hospice. Although an increasing number of deaths in East Sussex are taking place in people's usual place of residence or in hospices, fewer people in Hastings and Rother die in their preferred place of death than other parts of the county and most people still die in hospital. Due to an ageing population and longer life expectancies, the demand for end of life care will significantly increase over the next 20 years, and there is also increasing need for palliative care for disabled children and adults taking in to account medical advances in early life care and longer life expectancies for people with learning disabilities. Progress has been made to develop the local health and social care workforce to ensure it is structured, skilled and supported to deliver the best care and outcomes for local people approaching end of life and to provide more end of life care at home, in nursing and care homes or in hospices. It is crucial that this continues so that anyone approaching end of life is well cared for and has a "good death".

What we plan to do: Over the next three years we will support the development of a more consistent and joined up approach to End of Life Care by encouraging the End of Life Care pathway (from advanced care planning to bereavement support) to be rolled out and delivered through all public,

private and voluntary and community sector health and care providers. We also want to see continued End of Life Care training and workforce development for health and care staff and volunteers working in community, health and care settings to build sufficient capacity and skills to provide the highest quality of end of life care.

What we aim to achieve: We want more people who are approaching the end of life to be cared for and die in their preferred place of care and death and to receive the highest standards of end of life care in any setting. To achieve this outcome we would expect to see more people identified as approaching end of life to have an advanced care plan; fewer dying in hospital; more being cared for and dying in their preferred place of death; and staff who provide End of Life Care in community, health and care settings meeting the national End of Life Care core competencies and occupational standards.

5. DELIVERING AND MEASURING SUCCESS

a) Action plan

We are developing an action plan to deliver the strategy. This plan will set out the actions that the Board and other partners will take to deliver the priorities along with 'indicators of success' to help us monitor and measure progress.

In addition to the already agreed 'whole life' and 'integrated, whole system' approach the Board has agreed to include the following as key approaches to delivering the strategy: reducing inequalities; increasing prevention, early identification and early intervention; joining up with services beyond health and wellbeing; and building on individual and community strengths. Actions and targets relating to these approaches will, where appropriate, be included in the action plan.

The action plan will also include, where data is available, the areas and population groups that are experiencing the worst health and wellbeing currently to inform where actions may need to be targeted to reduce inequalities and 'narrow the gap'.

We will choose indicators that are relevant to East Sussex and will give us the information we need to know if we are succeeding. These will include indicators drawn from the national outcomes frameworks for the NHS, adult social care, children and public health.

b) Links to other strategies and plans

The following are key strategies, partnership plans and initiatives that this strategy aims to inform, complement and add value to (in alphabetical order):

- Adult Learning and Skills Strategy
- Carers Commissioning Strategy
- Children and Young People's Plan
- Clinical Commissioning Group plans
- Commissioning Grants Prospectus
- Community Safety Plan
- Dementia Care Delivery Plan
- Economic Development Strategy
- End of Life Care Joint Commissioning Strategy
- Environment and Climate Change Strategy
- Falls Prevention Strategy (Older People)
- Family Key Working multi-agency initiative
- Financial Inclusion Strategy
- Improving Life Chances Joint Commissioning Strategy for People with Physical Disabilities, Sensory Impairment and Long Term Conditions
- Integrated Local Area Workforce Development Strategy
- Learning Disability Joint Commissioning Strategy
- Living Longer Living Well Commissioning Strategy for Adults in Later Life and their Carers
- Local Transport Plan
- Mental Health Joint Commissioning Strategy
- Pathways to Independence and Support – Supported Housing and Housing Support Strategy
- Pride of Place, the East Sussex Sustainable Community Strategy

- Special Educational Needs Pathfinder Programme
- Substance Misuse Strategy

c) Finances

We are not in a position to provide information on local health and wellbeing budgets until:

- Government has confirmed the amount of funding being devolved for Public Health activities;
- Clinical Commissioning Groups have achieved authorisation; and
- Public sector bodies have finalised their budgets for 2012/13 and beyond.

It is important to note that many organisations will have to meet challenging savings targets over the next few years. Whatever money is available will need to be used more effectively to commission and deliver better outcomes whilst also ensuring health and care services are more efficient and affordable in the future.

d) Governance arrangements

This strategy is a framework for the commissioning of health and wellbeing services in the county. It will not replace existing commissioning plans, which will set out in much more detail the kinds of services being commissioned and where and how they will be delivered, but instead ensure that these plans are aligned with and help deliver the priorities set out in this strategy.

The Joint Commissioning Board will translate the strategy's priorities into joint commissioning priorities, oversee annual joint commissioning strategies and approve and monitor the deployment of the budgets (where they are pooled) and resources outlined in those strategies, ensuring the best use of available resources. The Health and Wellbeing Board will consider these joint commissioning strategies to ensure that they have taken into account the priorities and approaches set out in the Health and Wellbeing Strategy.

The Board will work with partners and partnerships across the public, private and voluntary and community sectors to strengthen the links between health, care and other services so that plans that affect health and wellbeing such as housing and housing support, community safety, education and skills, economic development, the environment, culture, leisure and community development help to promote individual, family and community wellbeing.

e) Monitoring, review and updates

The Health and Wellbeing Board will review progress against the outcome indicators and targets in the action plan each quarter. Our progress, the evidence base, the strategy and the action plan will be reviewed and refreshed each year to ensure that the Board can address any significant changes or developments. The annual review will be scheduled to inform the development of annual commissioning plans, business plans and budget setting.

The Joint Commissioning Board will oversee joint commissioning strategies and monitor the deployment of budgets (where they are pooled) and resources outlined in those strategies.

GLOSSARY OF TERMS

Clinical Commissioning Groups (CCG): Groups of GP practices and other representatives from health and the local community who will take on responsibility for commissioning healthcare services for patients and the general population in their area from April 2013 after Primary Care Trusts are abolished. In East Sussex, three CCGs have been established to commission health services in their local area, and are working towards being 'authorised' to carry out their duties.

Commissioning: Is the cycle of assessing the needs of local people, establishing priorities and strategic outcomes, specifying services, securing and delivering appropriate services and reviewing outcomes.

Community wellbeing: the extent to which local people, local services and infrastructure have the capacity to support or reduce wellbeing for everyone regardless of age, background or circumstances by creating and sustaining places that have decent and affordable homes, local shops, transport, jobs and opportunities to get a good education, and feel welcome, safe and have plenty going on so that people don't feel scared, lonely or isolated.

Health inequalities: The differences in health, life chances and life expectancy between different geographical areas and different groups of people.

Health and Wellbeing Board (HWB): The East Sussex Health and Wellbeing Board brings together Local Government, the NHS and the people of East Sussex. Members include local GPs, county councillors, senior County Council officers overseeing Public Health, Adult Social Care and Children's Services and the local Healthwatch. It will take on its statutory role in April 2013. Its main roles are to assess the needs of the local population through the Joint Strategic Needs Assessment; to produce a Health and Wellbeing Strategy to inform the commissioning of health, social care and public health services in East Sussex; and to promote greater integration across health and social care.

Health and Wellbeing Strategy: The high level, overarching framework within which commissioning plans for the NHS, social care, public health and other relevant and agreed services are developed.

Integrated care pathway: Is a multi-disciplinary plan to help a patient with a specific condition or set of symptoms to get the right care at the right time to achieve positive outcomes. Pathways are designed to reduce variation in practice and allow the same quality of care to be delivered to patients across multi-disciplinary and multi-agency teams and in different care settings.

Key worker: A professional practitioner who may be based in a range of services (from the Family Outreach Service to Probation or CRI substance misuse service) who leads and coordinates work to support an individual or family that needs coordinated support to tackle a range of health, care or other needs.

Local Healthwatch: Will assume the functions of Local Involvement Networks. It will act as the local consumer voice for people who use and need health and social care services, to provide information about health and care services, and support people to make choices.

Joint Commissioning Board: Oversees all joint commissioning activity across the NHS and East Sussex County Council for services where pooled budgets and/or other joint commissioning arrangements are in place. Members include representatives of the Clinical Commissioning Groups and senior County Council officers overseeing Public Health, Adult Social Care and Children's Services.

Joint Strategic Needs Assessment (JSNA): The JSNA provides an objective analysis of local, current and future health needs for adults and children. By assembling a wide range of quantitative and qualitative data, including the views of service users, it supports strategic planning and the commissioning of services. The East Sussex JSNA is available at http://www.eastsussexjsna.org.uk/

Local Government: Administrative authorities for local areas within England, with different arrangements in different areas. East Sussex is a 'three tier' area with a county council ('upper tier') responsible for, for example, schools, social services and public transport; five district and borough councils ('lower-tier') responsible for, for example, leisure services, recycling, etc.; and town and parish councils responsible for, for example, allotments, war memorials, local halls and community centres.

Looked After Children: Children and young people looked after by the state in accordance with relevant rules and regulations. This includes those who are subject to a Care Order or temporarily classed as looked after on a planned basis for short breaks or respite care.

Outcomes: The benefits a service user gains through a service, as distinct from activities and outputs which relate to more direct or immediate objectives. Thus, the outcome of training staff in end of life care will be that those approaching end of life and their carers feel more in control, involved and satisfied with the services they receive, whilst one of the outputs would be the number of staff trained.

Palliative care: Is an approach that improves the quality of life of patients, their families and carers facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Person centred (also referred to as 'personalised'): Sees patients, service users and their carers as equal partners in planning, developing and assessing their health and care to make sure services are most appropriate for their needs. It involves putting patients, their families and carers at the heart of all decisions.

Personal Budgets: The funding given to someone to meet their needs once they have been assessed as being eligible for social care support. They can have the money as a direct payment or can choose to manage it in different ways. Personal budgets are also being developed for health services.

Primary care: Services provided by GP practices, dental practices, community pharmacies and high street optometrists.

Primary Care Trusts (PCTs): The NHS body currently responsible for commissioning healthcare services for a local area. PCTs are being abolished under the Health and Social Care Bill and will cease to operate in April 2013 when Clinical Commissioning Groups will take over the commissioning of healthcare services.

Public Health: The protection and promotion of health and wellbeing outcomes and the reduction of health inequalities through the prevention of ill health and the prolonging of life through the organised efforts of society. From April 2013, the responsibility for many Public Health functions will move from Primary Care Trusts to 'upper tier' Local Government.

Re-ablement: Re-ablement is about helping people to do things for themselves rather than doing things to or doing things for people. It builds on what people currently can do, and supports them to regain skills to increase their confidence and independence.

Secondary care: Health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists. Secondary care includes hospitals.

Special Educational Needs (SEN): Is a legal definition referring to children who have learning difficulties or disabilities that make it harder for them to learn or access education than most children of the same age.

FOR MORE INFORMATION

For more information on the Health and Wellbeing Strategy and Health and Wellbeing Board please go to the webpage **http://www.eastsussex.gov.uk/yourcouncil/about/committees/meetings/healthwellbeing.htm** or contact Lisa Schrevel on:

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East Sussex's Better Care Fund

The Narrative to support the East Sussex Better Care Fund Plans

1.0 Introduction

The three East Sussex CCGs and Adult Social Care are establishing a Better Care Fund through the pooling of part of their budgets. The purpose of the Better Care Fund is to improve the experience and outcomes of people who our services by integrating health and social care to meet the needs of our population in an integrated, joined up way.

This document sets out how health and social care partners in East Sussex will design and deliver integrated health and social care for adults in East Sussex, as part of developing integrated out of hospital care, encompassing community health, social care, primary care and the private and voluntary sectors.

We recognise the need to substantially change and shift how we deliver health and social care to improve quality and efficiency across the system, the experience of clients and carers and to make the best use of our resources. The document describes how the Better Care Fund (BCF), will support the broader East Sussex 2020 Vision and The Green Triangle whole system change programmes that are being developed in East Sussex, underpinned by strategic financial and service planning. The BCF is an enabler of a number of these changes and of the delivery of our CCGs' and Adult Social Care longer term strategic vision around integrated care.

The issues and challenges facing the NHS and social care in East Sussex over the next 5 years are not new. These have been shared widely and are reflected in the commissioning plans implemented in 2013/14, the East Sussex Health and Wellbeing Strategy, the work plans of the Joint Commissioning Board and various delivery networks. These challenges can not be met by us doing more of the same, or solely through incremental change, particularly as organisations in East Sussex are facing significant pressures regarding performance and finance. We need to work collectively and consistently at a whole system level to deliver widespread, transformational change across primary care, integrated care, urgent care and planned care. Therefore this document brings the aspirations and needs of all organisations together to provide an overarching narrative within which partners will be able to develop comprehensive, integrated plans for the future.

The document has been produced by East Sussex CCGs and East Sussex County Council. We recognise the need to carry out service redesign and contingency planning in partnership with our providers, clients, carers and public. We will establish strong governance arrangements that will ensure East Sussex Healthcare Trust, Sussex Partnership Foundation Trust, Brighton and Sussex University Hospital NHS Trust, and Maidstone and Tunbridge Wells NHS Trust are involved in discussions and planning from an early stage. We see this as an iterative process which also needs to be embedded into the commissioning cycle. The CCGs and Local Authority will build on current involvement arrangements with clients, carers, the general public and third sector to ensure they are engaged in the detailed developed of integrated services shaping plans and priorities.

2.0 Our vision for East Sussex

Our vision is to create a health and social care system that promotes health and wellbeing, prevents ill health and improves the outcomes and experience of our population. This will be delivered through a focus on population needs, better prevention, self care, improved detection, early intervention, proactive and joined up response to people that require care and support across traditional organisational and geographical boundaries.

We also want to maximise the value we get from the health and social care investment, building capacity in our communities, primary care, community health care, social care, the voluntary sector and other providers to enable people to keep as mentally and physically healthy and independent for as long as possible.

Where appropriate and practical we will make additional investment in primary care and community based services that will deliver real alternatives to acute hospital based care, meaning that only care that has to be provided in an acute hospital setting will be delivered there. This will move care and support away from acute hospitals and institutional care settings to the local community and homes where people live.

When a person does need acute hospital care, we will ensure that not only can they access safe high quality care but they are then discharged in a timely and planned manner to continue to live as independently as possible at home.

Promoting good mental health, including taking preventative actions and providing support early on is a priority, to improve the wellbeing, quality of life and health of those living with and recovering from mental illness

We will achieve this vision by:

- Reviewing how health and social care resources are currently used to ensure we are maximising the use of public money to meet the needs of our population
- Jointly developing commissioning priorities across primary, community health, social care and the secondary care, to design an integrated health and care system at a locality level to deliver the outcomes required for clients and carers.
- Understanding and tackling health inequalities, ensuring we meet the diverse requirements of our population, and taking into account the different needs of rural and urban localities and those client flows to acute settings of care outside of East Sussex.
- Providing person centred care, enabling clients and carers to be partners in the design and delivery of their own care, with the back up of professional expertise and support where needed. Clients will be actively involved in making choices about improving their health and well being through self management, involvement in care planning and use of personal budgets. Understanding and addressing the needs of carers in service provision is seen as a key priority, particularly given the demographic challenges in East Sussex.

3.0 The case for change

Our population and the way we deliver health and social care support is changing, providing our local economy with many challenges as well as opportunities:

- Demand and need for care is growing in East Sussex as our residents live longer, with chronic and lifestyle diseases becoming more common. Our JSNA details the size of the challenge we must address as a whole economy.
- Developments in diagnosis, treatment and assistive technology means we can do far more to support people at home and in the community rather than provide care in traditional bed based settings.
- We need to do more with less resources as the reality of financial constraints affecting all public sector organisations is realised
- A shift to more self care, preventative, early intervention and care at home will reduce demand on hospitals and enable us to meet demand within available resources
- Partnership working across primary, community health and social care and the third sector is key to improving access, quality and capacity to deliver the right care outside of hospital.

4.0 What will be different

- Improved client and carer information and education to support decision making and self management
- Improved, coordinated access into primary care, community health and social care services
- Integrated front line delivery and processes to provide joined up care 7 days a week, particularly where it prevents inappropriate admission to hospital
- Strengthened locality working, with services designed to reflect local demand and need and delivered as close to home as possible
- Integrated strategies to shift resources from acute or institutional care to community based settings so that planned and unplanned care is delivered in the right place at the right time
- Integrated governance that sets the framework for strategic planning, resource allocation and accountability, including the use of pooled budgets

5.0 How our plans will have a practical impact on the care of individuals

The development of the BCF provides a significant opportunity to meet the priorities identified by our communities. A shift to community based services, with better integration and coordination between organisations is a strong theme coming out of each of the CCGs public and client engagement events.

Clients, carers and the public have asked us to change the way we deliver services for people with long term conditions, particularly for clients who have complex medical and mental health issues. Participants at these events identified that better integration of resources and holistic health and

social care assessment would deliver "better communication, better confidence, better experience, more efficient, prevents complications, risks to patients if less people"[1].

The priorities and changes identified at the 2013 *Shaping Health Services* engagement events strongly align to the National Voices narrative for person centred care. We will use the outcome driven statements like those in Appendix X to guide development of services and to identifying what success would look like for the people that use our services.

These changes will have an impact on the way in which clients and carers access services. Some services will be closer geographically, while other services will be accessed in different ways to that which they currently are, or require travel to more centralised or specialised centres. It may also mean that some services that are currently available may not be going forward. All of this will be discussed openly with the public and with stakeholders in a transparent way

6.0 Key components of the integrated system of health and social care

6.1 Changing the setting and model of care

In the future clients will be able to receive their care in a variety of settings based on clinical priorities and what delivers the best outcomes. Where possible, care will be provided at home, or close to home, with clients accessing appropriate care in settings outside of the traditional acute hospital settings. This change to out of hospital care will require investment in alternative service models, with more resource being used to provide care at home, in GP surgeries, in other local facilities and outpatient clinics.

The broader 5 year strategies that will be developed by NHS partners will consider opportunities for:

a) Promoting health and wellbeing, early intervention and self care
b) Shifting planned activity from secondary care into the community
c) Procedures as an outpatient setting rather than as a day case
d) The use of A&E for urgent care needs only where it can't be dealt with by other services
e) Keeping the time spent in hospital a minimum by improving discharge processes

6.2 Improving Primary Care

Primary Care is central to transforming the care and support clients receive in the community. If primary care is to truly coordinate and transform care, primary care itself must be transformed to ensure it is fit for the future and meets clients' needs. East Sussex's CCGs, working with NHS England, will continue to develop strategies to achieve this transformation.

The role of General Practice is unique in that it encompasses both the provider and the commissioner role. This dual role is to be embraced and exploited to the full but clear and strong governance processes are needed to maximise these service development opportunities fairly and in the interests of local people.

[1] H&R CCG Shaping Health Services Event 27.06.13 – Event Report

Improving access to primary care, and delivering a wider range of services in a flexible way, will make primary care the setting for many services rather than hospitals. This will require improved access at weekends and later into the evenings to provide 7 day care that is more convenient and responsive to the needs of the population. The changes and improvements are not just limited to General Practice, as Pharmacy, Ophthalmology and Dentistry are also key to preventative and proactive care.

GPs, working in a multidisciplinary way with health and social care professionals and the third sector are a focal element of delivering integrated and proactive care for people at greatest risk of becoming ill or needing intensive support. Evidence suggests that client care can be delivered most effectively by integrated community based health and social care services working at a locality level[2]. GP practices, linked to these multidisciplinary teams, would provide a locally responsive health and social care service based around a locality population of approximately 50,000 people. This would provide a holistic approach to assessment and care planning to provide a seamless health and social care service for those clients and carers that need integrated packages of care. Our vision for the future is that these localities will become a key vehicle for both commissioning of services and for the provision of many safe, good quality, sustainable, integrated health and social care services. IMT will play a key role in enabling these developments.

This demonstrates the interdependency in changing the way primary care and the community health and social care teams work together. Improvement plans for primary care and integrated care will be developed concurrently to make these linkages explicit.

6.3 Supporting Older People and those with Long Term Conditions

The long term conditions model focuses on pro-active management to meet people's care and support needs; promoting and enabling self care, improving access and choice through more convenient and planned options for care, and making services more cohesive so that care is better co-ordinated and the system of care is less complex.

Transforming the way the system works will help prepare people with the correct information and connect them with the right advice or treatment, at the right time and in the right place. Developing and extending care closer to home and providing more support to people to navigate the system will also relieve pressure on emergency services, allowing them to concentrate on treating those with the appropriate highest level of need.

The three key elements of the model are:

1. **Understanding the population** – improving business intelligence and using risk profiling to understand the needs of the population.
2. **Promoting Health and Supported Self Management** – empowering clients to improve their health maximise self-management and choice. Ensuring that patients are offered a personal care plan and have appropriate information about how to manage their condition e.g. through education, support and assistive technology.
3. **Integrated Care and Support** –Integrated health and social care teams built around a locality to provide joined up assessment, care planning and personalised services.

[2] A guide to the Implementation of the Long Term Conditions Model of Care: LTC QIPP programme

6.4 How we will deliver better care

Our 2014/15 commissioning intentions and existing primary care, integrated care and urgent care work programmes show our commitment to enable people to live as independently as possible and in the most appropriate place according to their needs. We are already working on a range of work programmes, but we need to increase the scale and pace of change. We will review and build on what we are already doing to ensure what we deliver is bolder and more integrated.

The East Sussex 2020 Vision includes five key system elements and objectives:

1. Increased preventative care and promotion of health and wellbeing
2. Multi-disciplinary health, social care, voluntary sector and community working
3. Improved outcomes for clients/ population
4. Improved client experience
5. Financially sustainability for the whole system

The schemes/areas to be developed to achieve the objectives are outlined below.

Scheme/area for development	**Outcome**
Using business intelligence and risk profiling to understand needs	• Use information on people's use of health care to identify those at risk of further deterioration and who would benefit from review and co-ordinated support • Social care and health data is used to better detect those with increasing need
Pro-active care and Care planning	• Personalised care plans for health and social care needs, with a focus on our most vulnerable patients/communities • Integrated records across health and social care • Strong working relationships at local level (community nursing, community pharmacy, optometry, Out of Hours providers etc) • Easy access to a specialist opinion/intervention when needed
Older people and people with LTCs empowered to self-manage	• Develop approaches to support community capacity building and self resilience • Improve Dementia diagnosis and support • Increase availability of support to Carer's • Invest in evidence based preventative initiatives such as specialist falls, fracture liaison and preventative exercise programmes
Integrated health and social care locality teams	• Develop a single point of access for community health and social care services to support pathways between services • Invest in community rehabilitation and reablement services, to help people in their own homes to recover from ill health, increase their independence or better manage long term conditions • Develop coordinated care through locality based multidisciplinary teams tailored to the needs of the local population and implementation of key working for those with highest needs • Support people to better manage their conditions themselves

	through proactive holistic support planning and self management
Shifting planned activity from secondary care into the community	• Shift resources from hospital to community settings where safe, practical and cost effective • Share resources between practices where it makes sense • Redesign our services and premises accordingly
Faster access to specialist assessment and diagnostics	• Provide access to acute specialist advice for GPs to avoid the need to admit • Improve the provision for ambulatory assessment and treatment at the front of hospital reducing the need to admit for key conditions • Provide community based care of older people specialists
Procedures in an outpatient setting rather than as a day case	• Establish those procedures that are more appropriately provided in clinics etc rather than acute day case
Improved access to primary care and locally-focused diverse provision based on local need	• Level up the quality for all clients of all practices • Provide transparent peer support and challenge to improve quality/safety • Provide strong education and training • Provide both a universal/population and an individual focus
Increased access to rapid support in people's own homes and supported decision-making about people with urgent care needs	• Provide therapy and reablement services 7 days a week • Provide urgent response nursing, including overnight • Develop capacity in community nursing to provide enhanced nursing care such as intravenous antibiotics • Provide rapid response to homecare
Use of A&E for urgent care needs only when can't be dealt with by other services	• Improved communication between urgent care services and front line clinicians, by using IBIS & the summary care record to share patient level information between services • Ambulance crews have access to advice and alternative services • Develop pathways to support people with acute conditions that are able to be managed in the community
Support for people who need bed-based care	• Redesign intermediate care bed pathways so people can access the right support and return home more quickly • Support Care Homes better through access to community services, training and guidance • Emergency and elective patients have early MDT assessments to ensure timely discharge from acute settings
Minimising time spent in hospital by improving discharge	• Implement 7 day working • Improved discharge planning and co-ordination of post-discharge needs for care and support • Improved response times for home care provision

7.0 Key enabling factors to deliver the change

We are clear about what needs to be in place to deliver our ambitions. We see the development of the following enablers within the next 12 months as critical to measuring and delivering successfully:

The key enabling factors needed to deliver the changes are:

- Integrated leadership and governance arrangements between commissioning and provider organisations
- Clear and aligned work programmes, performance management and accountability arrangements for delivery networks.
- Increased effective client and carer engagement and use of client centred outcome measures
- A shift to outcome based service specifications and ensuring we have the right contracts and incentives in place to align providers, support new ways of working, encourage integration and improve outcomes
- Developing our information systems and tools to improve our understanding of how each component of the health and social care system impacts on another, and to support the delivery of integrated care
- Development of strategies and integrated delivery plans that align primary care, community care and secondary care sectors, to support whole system redesign and improvement
- Development of an integrated workforce strategy to deliver the workforce required to make our plans a reality

7.1 Integrated Governance

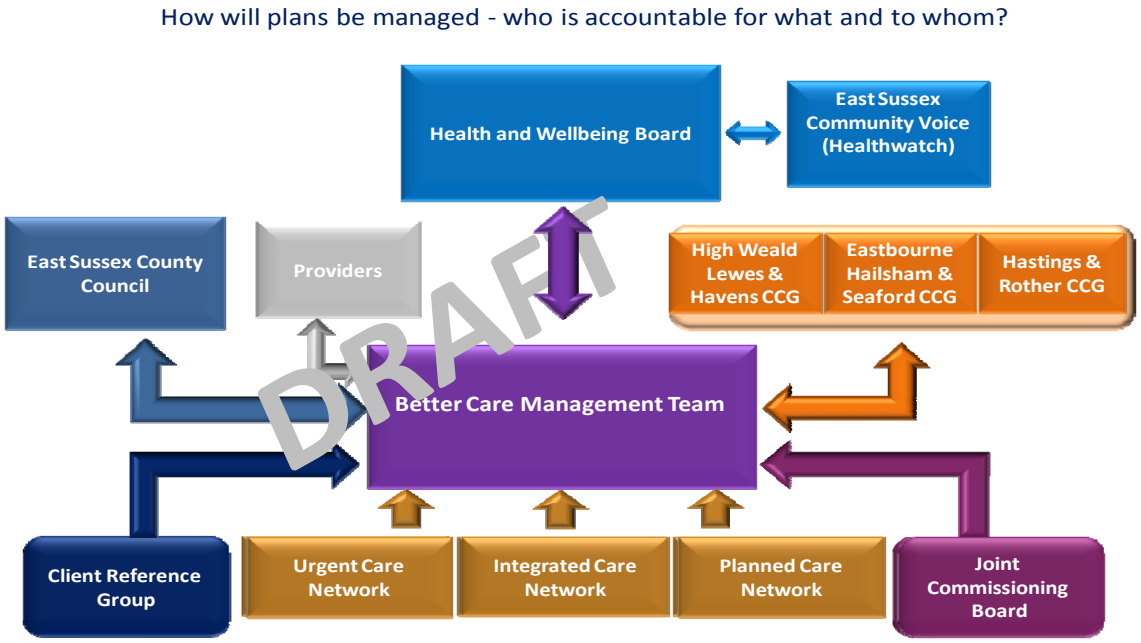
Our complex system, and the challenges individual organisations face, requires better partnership arrangements than ever before. Leaders from all of the NHS organisations in East Sussex and Adult Social Care, and Healthwatch have come together to discuss the best way to take forward the transformation required as part of realising East Sussex 2020 Vision and The Green Triangle.

As partners we will need to work collectively for the whole system to create, agree and implement a clear and credible plan for a sustainable system of health and social care to secure the best possible outcomes for East Sussex residents, over and above immediate organisation interests.

Good governance between East Sussex organisations will provide the direction and leadership for the system, assurance that BCF programmes are working together to deliver the overall strategic objectives and that risks have been identified and managed.

We will look to develop our governance arrangements in line with the diagram below:

Diagram 1: Potential East Sussex Governance structures



7.2 Whole System working

We need to develop a strategy for how we will commission out of hospital services and primary care improvements. This will be an iterative process, with strong clinical leadership and involvement from our key providers.

7.3 Integrating Health and Social Care through the Better Care Fund

Once we have developed our strategy, it is expected a number of the system changes required will be facilitated by the East Sussex's Better Care Fund. The fund provides an opportunity to accelerate the integration between health and social care, with significant expansion in community services. The BCF will require health and social care partners to set out the resources that will be brought together under a pooled budget, and the associated 2 year plan for the use of these resources to deliver integrated care with better outcomes for clients and carers. The expectation is that this will require deployment of core health and social care investment which is broader than the proposed BCF.

The pooled fund outlined in Table 1 will bring together resources that are already committed to delivering existing activity, therefore partners will be redirecting funds from these activities into a shared programme of investment which will deliver better outcomes. Investment will require service transformation and clear agreements will be developed to manage the impact of any subsequent disinvestment, particularly in acute care services.

Table 1 East Sussex Better Care Fund minimum allocations

Resources	2014/15 (000)	2015/16 (000)
Social care (Health Transfer)	9,263	n/a
	2,155	
Social Care Capital Grants	n/a	1,440
DFG	n/a	3,107
HWLH CCG		10, 614
EHS CCG		12,749
H&R CCG		13,188
TOTAL	**11,378**	**41,098**

Table 2 High level deployment of allocation

Resources	2014/15 (000)	2015/16 (000)
Social care (Health Transfer)	9,263	11,850
Additional Social care (Health Transfer)	2,155	n/a
NHS Reablement funding	n/a	3,100
NHS Carers	n/a	1,500
Social Care Capital Grant	n/a	1,440
DFG	n/a	3,107
CCG funding (remainder)	n/a	20,201
TOTAL	**11,378**	**41,098**

The allocations above are the minimum amount of funds to be included in the pooled budget. The BCF will provide part of the investment required to achieve the shared vision for health and social care, and as transformation plans are developed partner organisations are able to extend the scope of the pooled budget where it supports integration.

Investment decision making process will ensure that investment in services support:
Protection for social care services: Protecting social care services in East Sussex means continuing to ensure adults who are at risk of harm, abuse or neglect are safe, and helping people to live independently for as long as possible, through person centred support . We are working hard to make sure that we provide the right support to people who need it, and whilst maintaining eligibility criteria is one element of this, we are also looking at ways of preventing people from needing support in the first place.

Year on year we continue to support people to remain living independently in their own homes, with maximum choice and control over the support they receive. Within the context of growing demand and significant budgetary pressures we want to continue to develop personalised services by approaching them in a more innovative way. We want to help more people to help themselves , as well as focusing on reablement and more proactive support to ensure people remain well, are engaged is self management , and where ever possible are improve people's independence so they can stay within their own home.

- Protecting social care services: In East Sussex this means continuing to ensure adults who are at risk of harm, abuse or neglect are safe, and helping people to live independently for as long as possible, through person centred support . We are working hard to make sure that we provide the right support to people who need it, and whilst maintaining eligibility criteria is one element of this, we are also looking at ways of preventing people from needing support in the first place.

- Development of 7 day working: East Sussex has a good record of investing in community services that deliver "7 day working" in an integrated delivery model. This includes our integrated services such as the Joint Community Rehabilitation Team, Integrated Community Access Point, Integrated Night Service as well as a range of other core services including the District Nursing teams and homecare providers. There is however more that we can do to ensure there is a systematic whole system approach to 7 day service delivery.

  NHS Improvement has identified four levels to assess and plan the delivery of seven day services[3]. This provides a framework for service models to be reviewed against and identify further areas where seven day working will support admission prevention, early diagnosis and intervention and/or early supported discharge.

- Better data sharing between health and social care based on the NHS number, including IG issues: By April 2016, the NHS Number will be used as the primary identifier across East Sussex.

- Strengthening of joint assessments and care planning, with accountable lead professionals: East Sussex has been developing multidisciplinary working, centred around risk stratification of GP Practice populations using Sussex Combined Predictive Mechanism (CPM). Emerging Primary Care strategies envision GPs taking a lead in coordinating care for people at high risk of hospital admission. Further work will be undertaken to define and implement locality models of care, ensuring accountable lead professionals are allocated and care plans are in place for the identified client cohorts.

The delivery of the plan requires active participation and agreement of commissioners and providers, including acute and mental health services to design and deliver a holistic approach to health and care services and strong community engagement and support.

A specific element of the funding has been made available during 2014/15 to build momentum towards delivering the expected transformation of our system. This funding will be used for programme support, developing and implementing the enablers for system change and to make rapid progress on agreed priority areas.

We will also be putting into place the necessary risk sharing and contingency planning arrangements for the BCF, linked as appropriate to whole system change.

9.0 How we will know we are successful

Delivery against the BCF 2 year plan, CCG 2 year operational plans and towards the 5 year strategies

[3] Equality for all: delivering safe care- seven days a week

In 2014/15 we will have developed

- Strong leadership and governance measures
- Detailed plans for
  - Recording and measuring client and carer experience and outcomes
  - Ensuring fair access to high quality services across the county
  - Supporting the health and social care system to balance economically
  - Strong commissioning and procurement processes
  - Integrated workforce plans
- Progress against the national conditions and metrics of the BCF:
  - Protection of adult social care services
  - Providing 7 day services to support clients being discharged and prevent unnecessary admissions at weekends
  - Agreement of the consequential impact of changes on the acute sector
  - Ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
  - Delayed transfers of care
  - Avoidable emergency hospital admissions

From 2015/16 we will see

- Beginning to shift of resources and activity from acute/institutional care into primary care, other out of hospital settings and in people's own homes
- Preventative care with earlier access to assessment, diagnosis and intervention
- Improved population health outcomes
- Workforce planning begins to deliver the workforce required by all partners
- Further progress against the 2014/15 national conditions and metrics and additional 15/16 metrics of the BCF:
  - Effectiveness of reablement
  - Admissions to residential and nursing care
  - Patient and service user experience.

10.0 Next steps

The BCF 2 year plan is part of a wider and longer programme to integrate care and improve the health and wellbeing of East Sussex's population. The BCF does not come into full effect until 2015/16 however we will be building momentum during 2014/15. We will look to allocate the additional £2.1M East Sussex will receive to begin the transformation required and ensure progress is made against expected performance requirements.

Version Control

Version	Date	Amendment History
0.1	22/10/13	Initial paper on Out of hospital strategy - draft for discussion CA and BH
0.2	12/11/13	Amendments made to reflect discussion and presented to JCOG for comment
0.3	18/11/13	Amendments made in advance of meeting to discuss Out of Hospital Blueprint CA, AS, JOs, IG, MS
0.4	22/11/13	Out of Hospital Blueprint Working draft to CA, AS, BH
0.5	25/11/13	Out of Hospital Blueprint Working draft
0.6	2/12/13	Out of Hospital Blueprint to Joint Commissioning Board and JCOG
0.7	10/12/13	Amendments made to reflect JCB and JCOG discussion; shared ahead of further discussion on 12/12 with CA, MK, AS, WC
0.8	12/12/13	Amendment following discussion with AS, CA, FS, MK
0.9	16/12/13	Amendments made to reflect discussion and comments
0.10	17/12/13	Amendments made to reflect planning guidance and change to Better Care Fund. Circulated to JCOG for further comment
0.11	03/01/14	Amendments made to reflect comments from MK, re-circulated to JCOG in advance of meeting 10/01/14
0.12	09/01/14	Amendments made to reflect comments from JCOG members received in advance of meeting 10/01/14
0.13 Final draft for submission	14/01/14	Amendments made to reflect comments from JCOG members at and following the meetings on 10/01/14 and 13/01/14.

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 (000)	Minimum contribution (15/16)	Actual contribution (15/16)
East Sussex County Council	*TBD*	11,378	4,547	*TBD*
Eastbourne, Hailsham and Seaford CCG	*TBD*	2,356	12,749	*TBD*
Hastings and Rother CCG	*TBD*	2,515	13,188	*TBD*
High Weald, Lewes, Havens CCG	*TBD*	1,879	10,614	*TBD*
BCF Total	***TBD***	**18,128**	**41,098**	*TBD*

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

BCF schemes in 14/15 will be funded via the s.256 transfer from NHS England to East Sussex County Council and the 1% non recurrent expenditure to transform services and help manage the transition to new patterns of provision.

Contingency plan:		2015/16	Ongoing
Outcome 1; Admissions to residential and care homes	Planned savings (if targets fully achieved)	TBD	TBD
	Maximum support needed for other services (if targets not achieved)	TBD	TBD
Outcome 2: effectiveness of reablement	Planned savings (if targets fully achieved)	TBD	TBD
	Maximum support needed for other services (if targets not achieved)	TBD	TBD
Outcome 3: delayed transfer of care	Planned savings (if targets fully achieved)	TBD	TBD