Introduction

National picture of future demand for community services for people with Long Term Conditions

Currently there are 15 million people living with a Long Term Condition (LTC) in England they are the main driver of cost and activity accounting for around 70% of overall health and care spend. Nationally evidence shows that this group of people are disproportionately higher users of health services, representing 50% of GP appointments, 64% of outpatient attendances, 70% of inpatient bed days, 58% of A&E attendances and 59% of practice nurse appointments. Demographic projections outline a 252% rise in the number of people over 65 by 2050 and consequently one or more long term condition. While the number of people with any long term condition is predicted to be relatively stable over the next 10 years, there will be a 60% increase in the number of people with three or more long term conditions over a ten year period (2006-2016). In a quarter of people with multiple long term conditions, one of them will be depression. (QIPP LTC work stream Commissioning Development Programme Operational Phase Members Guide 2012)

To address the challenges of increased co-morbidities both health and social care are undergoing significant changes in their approach to care, moving away from support and the treatment of disease or condition specific pathways and moving instead towards re-ablement and wellbeing models.

This approach is supported and encouraged by the following key national policy drivers:

- Better access to services, more local provision, and commissioning care to support wellbeing through preventative measures highlighted by Lord Darzi's Review, High Quality Care for All and Transforming Community Services (DOH High Quality Care for All, 2008 and Transforming Community Services 2009)
- Putting People First through needs based commissioning to provide equitable access to services and a single community based support system. (DOH Putting People First, 2007)
- Halfway Home- Department of Health 2009 recognising Intermediate Care as a continuum and encouraging integration between health led rehabilitation and social care led reablement.

Commissioning Intentions

Commissioning intentions and provider plans have been developed based on an analysis of the local demographic, the current challenges and projections of future need. Their implementation will ensure that local services can meet local needs by providing the right care in the right place at the right time and will deliver:

- Improved quality and safety,
- Improved outcomes for patients,
- Improved patient experience and
- Sustainability and affordability

The strategic plans for transforming services in East Sussex centre on moving the emphasis from traditional divisions between health and social care and hospital and primary care to a much more integrated or joined up pattern of services. They reflect the intention to shift the setting of care from acute hospitals to community and primary care provision wherever appropriate and to raise the quality and improve the sustainability of the services provided in all settings. Services will be clinically led and will put patients at the heart of self-management and self-care. The majority of this transformational change can be delivered through improving the design of services. However, in some instances re-design and efficiency will not be sufficient to meet the aim of improving services and achieving improved outcomes for patients.

In 2009 an "Integrated Plan for Health, Social Care and Wellbeing" (Integrated Plan, 2009) was commissioned and written including both Adult and Children's services across health and social care and the ESCC Chief Executive's department. This was ratified by cabinet in April 2010 and the PCT Boards in May 2010. The Integrated Plan described a programme of integration between health and social care around intermediate care and long term conditions. Since the ratification of the Integrated Plan, the coalition government's strategy for the NHS "Equity & Excellence; Liberating the NHS" has been published. This emphasises the need for joined up services, and defines a role for statutory health and well being boards within local authorities to promote integration, including joined up commissioning of local NHS services, social care and health improvement. Additionally, the Long Term Conditions QIPP agenda is a clear driver for further health and social care integration.

Evidence Base

Service users universally say that they wish to be treated as a whole person and for the NHS and Social Service to act as one team. Despite this, those people who have

more than one condition, particularly older people, or those at point of crisis face an increasingly fragmented response.

The needs of people with long term conditions transcend the traditional organisational boundaries of social, primary, community and secondary care. The current system fragments care for individual service users and the lack of continuity often leads to poorer outcomes and inappropriate secondary care usage.

An integrated model for community services and management of those with a long term condition is guided upon three key principles:

(1) Risk Profiling
(2) Neighbourhood Support Teams
(3) Self care/shared decision making

A model based upon these three principles has received widespread support from organisations such as The Kings Fund as it has been shown to improve clinical outcomes and reduce unscheduled admissions to secondary care/admissions to nursing/residential homes. This model has now been adopted by the local health economy and forms the basis of the changes to the community services. Redefining community services around these founding principles leads to the development of a health and social care system that is preventative, anticipatory in approach to managing long term conditions on a whole person basis leading to reduced secondary care.

An effective and proactive prevention focused Neighbourhood Support Team approach can have positive impacts on the whole health and social care system, preventing inappropriate escalation of services (A&E attendances, inpatient admittance and nursing residential home placements) resulting in better quality outcomes for patients and greater financial efficiency.

East Sussex Healthcare

East Sussex Community Healthcare Services integrated with East Sussex Hospitals Trust on 1st April 2011 to become East Sussex Healthcare, a community and acute integrated trust. Since then ESHT has developed a clinical strategy: Shaping our Future. The overall aim of this strategy is to ensure the provision of sustainable services which improve the healthcare outcomes for local people. Delivering this aim requires a local health economy wide approach to improving the quality of care by ensuring the services are integrated and patients are treated in the right place, at the right time by health and social care teams that are appropriately skilled and resourced.

The management structure within ESHT has been redesigned to maximise the benefits of bringing the acute and community elements of a clinical pathway

together, under the responsibility of one management team in a clinical unit. A good example of this is stroke care; which now has one clinical service manager responsible for the acute elements of the pathway as well as the rehabilitation that follows in community.
A wide range of community services are provided by ESHT for adults and older people.

Community hospitals / beds
Intermediate Care beds are provided in 5 community hospitals at Rye, Bexhill (Irvine Unit), Uckfield, Lewes and Crowborough as well as a joint provision with Adult Social Care at Firwood Intermediate Care Unit in Eastbourne. The Irvine Unit provides the dedicated stroke rehabilitation beds. Uckfield, Bexhill and Crowborough have minor injury units. Outpatient services and diagnostics (X ray, Ultrasound and Dexa scanning), are provided at all the community hospitals and day surgery from Uckfield, Bexhill and Crowborough.

Community teams
The are currently a wide range of community teams including District Nursing, Advanced Community Nurse practitioner services, specialist nurses for Heart Failure, Diabetes, Respiratory, Tissue Viability, Lymphoedema, Continence management, as well as community rehabilitation teams (including nursing and therapies), Falls prevention, Podiatry, Wheelchair Services, Dietetics and Specialist Community dental services and a joint county wide Integrated Night Service.

In addition we provide a health and wellbeing service for improving lifestyle through diet and nutrition, exercise and smoking cessation.

Benefits achieved since integration in 2011
Since the creation of the integrated trust a number of service improvements, initiatives, and service developments have been implemented that are delivering a more effective and efficient service for the patients of East Sussex. These initiatives will support the models of care identified by the strategy and are all aimed at supporting the Trust's key objectives:-

- Keeping more people safely in their preferred place of residence and
- Avoiding unnecessary acute hospital admission as well as
- Promoting a model of working in partnership with patients, adult social care, primary care, Sussex Partnerships Trust, the ambulance services and voluntary sector.

Early Supported Discharge encompasses a range of schemes that ESHT have introduced to help bring people home earlier from an acute hospital episode by providing an intensive input at home from therapy and nursing teams. We now routinely provide this model of care for Orthopaedics (ADS), Trauma (TADS), patients

with dementia (DADs), stroke (Stroke ESD) and we intend to continue to develop this model further as part of our strategic direction.

We already provide day case surgery at Uckfield and Bexhill community hospitals and outpatient services in all 5 community hospitals and have increased the percentage of day surgery undertaken in the community and the range of procedures.

Integrating our services with other partners to improve patient care

Neighbourhood Support Teams are being introduced in phases and ultimately will bring together adult social care, community NHS and mental health services into a single generic service, provided by 12 locality based teams. There will be a single point of access for all community services, with multidisciplinary meetings to discuss key worker arrangements and shared care plans and documentation. Unless absolutely necessary provision will not be condition specific, but will be provided on the basis of need. Specialist services such as Stroke Neuro-Rehab, or Trauma Assisted Discharge will be accessed as required.

This year as Phase 1 of developing Neighbourhood Support Teams (NSTs) we have joined together our community rehabilitation services with the Living at Home (LAHS) service in Adult Social Care to create a joint community rehab (JCR) service. Additional funding has also been agreed to enhance the new JCR service.

Increasing utilisation of Community/Intermediate Care beds

The use of community beds across ESHT is currently under review as part of the community redesign programme. Early performance reports show that occupancy rates for Intermediate Care beds rose to 91% for July 2012, which is evidence of the improved management across the acute and community pathway. The current focus for community beds is to avoid acute admissions through "step up" referrals into a community bed, as well as providing "step down" for patients who are medically fit but not able to be discharged home. The NSTs will help to support patients in both the step up and step down community beds.

Training GP colleagues in Primary Care

ESHT has begun sending our acute consultants to GP practices to improve skills and knowledge in primary care that will help manage patients appropriately in the community, avoiding unnecessary referral to acute services. Cardiology, Diabetes, Respiratory consultants have already started this training and ESHT intend to roll this out wider to include more specialities, over the next year.

Future direction and next steps

To further improve and increase service provision in the community our plans for the rest of 2012/13 and beyond include the following projects:

Neighbourhood Support Teams (NSTs) Phase2
In October this year, the second phase of NSTs will bring together district nursing services, integrated night services, Social Worker practitioners, Advanced Community Nurse practitioners (previously known as Community Matrons) and Psychiatric Nurses to join with the Joint Community Rehab services that came together in Phase 1. This will be the second phase in a 4 phase roll out of the NST concept as described above. The last 2 phases will include the community intermediate care beds and specialist community nursing services.

Admission Avoidance in partnership with the ambulance service (SECAMB)
To help provide patients with a better alternative to an acute admission to hospital we are currently working with SECAMB to share information on patients who are at risk of an admission. We are adding to the SECAMB IBIS data system to enable our teams to join up to create a rapid response alternative in the community that maintains the patient safely in their place of residence.

Improving End of Life Care (EOLC)
We are also joining up with SECAMB to share our information on EOLC to support patients who wish to die in their home instead of being admitted into an acute hospital bed.

Whole system enablers

There are 3 whole system Network Boards: Integrated / Intermediate Care Network Board, Urgent Care Network Board and Planned Care Network Board. These Boards each have whole system shared objectives and they meet every month to performance manage and coordinate the improvement of future service provision, particularly focusing on increasing service provision in the community. Key performance indicators include workforce (skill mix and numbers), funding arrangements, and benefits realisation. These are whole system boards and membership is from ESHT, PCT, CCGs, Secamb, Social Care and Out of Hours GP services.

How these developments in the community support Shaping our Future

Whilst there are specific changes within the community that specifically support the delivery of the clinical strategy with regard to orthopaedics, general surgery and stroke; it is vital to recognise the importance that all changes and service redesign will make in delivering the proposed models of care.

Work is currently underway within acute medicine and cardiology, in particular, that will reduce medical outliers (emergency medical patients in surgical beds), preventing avoidable admissions and cancellations; enabling patients to be streamed to the right bed and reduce patient's length of stay, releasing essential bed capacity. These changes will have significant impact on the ability for the specialities to deliver their models of care and delivery options.

Investment and resource requirements

The Trust in partnership with ESCC have identified with our commissioners that in order to deliver the required service models, we will need to ensure that some services are invested in, whilst some will need to be redesigned.
Services that will require additional investment include:

- Neighbourhood support teams
- Integrated imtermediate care teams
- Community respiratory team
- Community diabetic services
- Community heart failure services
- Community diagnostics, including additional scanning capacity
- Therapies (physiotherapy, speech and language, OT)
- Community diatetics
- Telehealth/telecare
- Hospital Intervention team
- Falls prevention

All of these initiatives and services are being worked through the 8 primary access points in terms of quantifying the appropriate levels of activity and resource required. This will form part of the contract negotiation with commissioners for 2013/14 and beyond. It is clear that savings achieved within acute care will enable the significant investment into community services thus keeping patients care closer to home and improving access across the county.

Orthopaedics
The strategic development within orthopaedics includes the introduction of therapies 7 days a week. This will enable ESHT to reduce the length of stay in the acute sector. The Assisted Discharge Service (ADS) and the Trauma Assisted Discharge service (TADS) will be expanded to provide a service to those patients that need it across ESHT. These services will work together with the Neighbourhood Support Teams in discharging people home, and ultimately will form part of the neighbourhood support teams

Stroke

The model of care for stroke services is to separate the acute and rehabilitation elements of stroke care, and to reduce the acute length of stay. Patients requiring further inpatient rehabilitation following their acute stay will have their care provided in a dedicated stroke rehabilitation unit in a community bed. An additional 6 dedicated stroke rehabilitation beds will be provided at the Irvine Unit in Bexhill, bringing the number to 18 rehab beds.

Additional non-recurrent funding has been received from the PCT for the Community Stroke Rehab Team / Early Supported Discharge for the Hastings & Rother and Eastbourne areas. Community Stroke rehab has not been commissioned from ESHT for the High Weald, Lewes and Havens area.

General Surgery

We are also improving the discharge process and shortening the length of acute hospital stay for patients receiving colorectal surgery through early involvement of a multidisciplinary programme involving community and hospital staff. This recovery assessment service assesses patients pre-admission to plan a better discharge, well in advance of their admission to hospital (Early Recovery After Surgery/ERAS). This service will be extended to cover additional conditions.

Financial Strategy

ESHT's overall financial strategy allows for £10m of investment in community services to cover the whole of the clinical strategy, and £6m of transitional support as services move to new models of care. Work is underway to quantify the exact investment required to deliver the proposed models of care. This investment will come from savings that are generated through the delivery of the clinical strategy for East Sussex by all partners in the local healthcare economy. Reducing unnecessary admissions, reducing length of stay and consolidating specialist teams are all ways in which ESHT will reduce its costs, to enable it to provide the appropriate resources required in community services.

It is important to recognise that future investment is a commissioning decision, so while our expectations of future community investment is a prudent approach, the exact detail is still to be agreed with CCGs and commissioners, and this process will be part of routine annual contracting negotiations.